

HEALTHY BODIES MATTER: ANALYSIS OF THE DISCLOSURE OF RACE
AND HEALTH CARE ON WEBMD.COM

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ABSTRACT

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Offline racial health and health care disparities have been well documented and researched. However there has not been as much research into how these offline disparities have translated into online environments. Specifically, this study examines health websites, with a focus primarily on WebMD.com, that have become ubiquitous to the process of obtaining health information which has become self-propelled by the consumer. The model of health care where by the medical professional serves a patient their knowledge in a one-way model has largely been phased out in favor of a fluid exchange in which patients also bring medical knowledge and information to the table. Overwhelmingly, the information that the patient contributes comes from cyber research from websites such as WebMD.com. The Health 2.0 movement has furthered the expectation of patients to be proactive members of their health care who should research their conditions, symptoms, and treatments in addition to seeking medical professionals advice. Health 2.0 is predicated on users data input into online health care environments. Users interact with each other to exchange information and provide medical support to each other in what seems to be a radical departure from a traditional paternalistic model of health care that helps to reinforce institutional racism that perpetuates racial health and health care disparities. However examining a health website such as WebMD.com reveals that not only has cyberspace not created a radical egalitarian arena for health information exchange, health care websites have largely perpetuated the same model of health care information exchange that information exchange in cyberspace in general and Health 2.0 specifically attempts to circumvent. Using

Michel Foucault's idea of the medical gaze, I analyzed WebMD.com as a site in which patients can learn the medical gaze and thus procure medical knowledge the same way that was previously limited to those entering medical school. As such this project shows how offline racial health care disparities are perpetuated through discourses of race and health on WebMD.com and how these discourses become a precursor to the Health 2.0 movement.

To Makena and Naren, hopefully when you are my age, a national health care system will be as normal as taxes.

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“It is health that is real wealth and not pieces of gold and silver.” –Gandhi

CHAPTER 1: INTRODUCTION

In a 2009 *New York Times* article, Bob Collier, a 62-year-old Georgia resident proclaimed, “We’ve got to do something about those people who can’t get [health] insurance.” He goes on to say, “There has to be a safety net there. But I don’t want that safety net to catch too many people” (Sack, 2009, para. 19). During the same year that Collier declares the need for a safety net, across the nation, Congressional representatives held town hall-style meetings as an opportunity for their constituents to ask questions about upcoming proposed health care legislation that would become the Affordable Care Act. The article aimed to draw readers’ attention away from the outbursts and outlandish behavior of some people who were attending these town hall meetings. Instead, Sack (2009) sought to show the thoughts of the mythical American “everyday citizen.” Collier worked for the same company since he graduated from high school, attended church regularly, and lived with his wife of over 30 years in the same four-bedroom home in which they raised their children.

Collier is an important figure precisely because he is not a high profile politician or news pundit. Collier, who was interviewed on his thoughts, questions, and concerns regarding the proposed national health care system, argues that his concern of “too many people” being saved by a health care safety net stems from his wife’s battle against cancer. He was concerned that his wife would not receive the same quality of health care under a federally regulated health care system. Collier’s health insurance that he receives through his job paid for the medical treatments that helped to save his wife’s life. Concern for the lives of loved ones is completely understandable and even expected; however, the underlying larger hegemonic ideologies of superiority and subsequent acceptance of privilege becomes evident throughout his interview.

Collier also stated, “This [universal health care] is about the future of our country as we know it, [. . .], and may mean the end of our country as we know it” (Sack, 2009, para. 7). The “end of our country as we know it” maybe troubling to those who are in a position of privilege and power; however, I would argue that people who occupy positions that render them powerless by the simple fact they occupy particular oppressed identity categories would not be troubled by an end to institutional oppressions. In terms of health care, a change to the current system can be seen as worrisome for those, like Collier, who have been privileged enough to receive quality health care.

On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act (Affordable Care Act) into law. The United States has a long history of various attempts at providing health care to its citizens with varying degrees of success. One of the first social service programs to be instituted in the United States was mandated from state legislatures that disabled veterans, widows, and children be given public aid in 1862 (Bradley and Taylor, 2013, p. 24). While this program was not an act of health care per se, it is noteworthy because it is a moment when the American government is requiring that government take care of the wellbeing of its citizens. We first encounter the concept of health insurance in our country in 1939 with the first Blue Shield insurance plans that covered physicians’ services. President Johnson established Medicaid and Medicare in 1965; this is the first type of health care that is government sponsored. Although other presidents have campaigned for some form of national health care for all citizens, it is not until President Obama’s signing of the Affordable Care Act in 2010 that the United States has a form of health care legislation for all citizens has been signed into law (Bradley and Taylor, 2013).

Even after this historic step towards health care equity in the US, health care reform continues to be a topic of much debate in the United States. After the signing of the Affordable Care Act and the election of the 112th Congress, House members voted over fifty times to repeal the law during its first four years of existence (O’Keefe, 2014). The topic has been fiercely debated on many levels - financial implications, intervention of government into citizens’ lives, quality and availability of care - but I would argue that what is underlying the debate is the notion of whose body is considered valuable enough to expend resources to ensure its survival. Whether people are supportive of universal health care or oppose it, the underlying issue is still the same: whose bodies are valuable enough to receive care? Thus the argument opposing universal health care are, in a sense, is a claim that only select bodies should be treated and maintained; in other words, health care and subsequent good health is a privilege. Conversely, the argument supporting universal health care can be interrupted as a claim that all bodies are worth care and treatment, or that health care is a human right. Looking at the microcosm of health and health care illuminates larger ideologies of superiority that require the belief that certain people – certain bodies - are more important than others. This project seeks to explore the ways that the discourse of health care can elucidate how bodies are valued differently. Furthermore, how can the discourse of health care in cyberspace on websites like WebMD.com reflect the discourse of health care in the offline world? In other words, how are bodies valued and what makes a body valuable? What can the way that we speak about health care tell us about this? Is one body more valuable than another body?

To determine if one body is more valuable than another, there must also be an examination of what differentiates one body from another. Historically, in American society a common way that bodies are often distinguished from one another is by the categories of gender,

race, and to a lesser extent class. Thus, in looking at differentiation of bodies it is important to also look at the ways that meaning is ascribed to the categories of race, gender, and class. For the purposes of the proceeding research, I have chosen to focus primarily on race to examine how difference is ascribed to bodies.¹ The examination of the discourse of a specific site of exploration, such as provision of health care, has the potential to illuminate definitions of race and how these definitions relate to placing value on bodies.

Valuing Bodies

To be able to bestow hierarchial value to bodies, first the difference between bodies must be delineated. Difference is not inherently problematic; difference becomes problematic when it is associated with privilege (Johnson, 2006). Peggy McIntosh (1988/2007) differentiates between unearned advantage and conferred dominance to describe the ways that privilege manifests itself. Unearned advantages are entitlements that are systematically offered to privileged groups, while conferred dominance is the assumption of empowerment of the dominant group over oppressed groups (McIntosh, 1988/2007). We can see both unearned advantage and conferred dominance in the above-mentioned *New York Times* article. Collier's assumption that he, his wife, and people like them, should be protected by a health care safety net but the safety net should not extend to everyone is an example of an unearned advantage. Our current system in the United States in which health care is attached to higher level employment is a systematic exclusion of people who are unemployed or working in lower status and lower paying jobs. The reporter chose to use a middle class, white male for an example of

¹ I would be remiss to not acknowledge the effects of intersectional identities and thus race as a category is simultaneously affected by class and gender as well. However, a through exploration of gender and class is outside the scope of this research.

the “average” American citizen, when in fact it is the representation of privileged identity categories. Considering Collier as a representation of the average American citizen whose concern for health care is paramount is an example of conferred dominance.

The concepts of unearned advantage and conferred dominance provide a framework for thinking about how ideologies and systems of superiority play out in society. Sack’s choice to use Collier as an example of an “average” American citizen is an example of the way hegemonic ideology subtly presents itself in everyday life. Hegemony acts as a societal regulator in which certain social groups are able to remain dominant by exerting sociopolitical control over other subordinate groups not merely through coercion, but by also eliciting consent from the masses (Hebdige, 1979/2007). Thus Sack’s choice of using Collier as an example of an “average” American citizen becomes a reflection of a pervasive societal acceptance of the notion that the average American is white, middle-class, and male which erases the presence of people who fall outside of this norm. Furthermore, it is a reflection of the acceptance of this type of body that Collier represents being highly valued. In terms of health care, that indicates an unspoken confirmation that bodies like Collier’s - white, male, middle-class – are important enough to receive health care and thus are important enough to remain healthy and to live as long as possible.

The acceptance in a system that agrees that it is fair to value bodies based on difference is not merely an individual’s belief; it is a reflection of societal ideology. While ideologies can be seen as being held by an individual, it is more accurate to say that ideologies are a reflection of a society’s superstructures. In other words, as Antonio Gramsci (1971/2006) alludes, individuals do not inherently have ideologies but rather they adhere to the ideologies of a system. Ideologies are a reflection of the ruling elites’ interest, not “average” citizens. As Marx and Engels

(1976/2001) argue those that hold the means of production are the ones who are able to create ideologies to which the masses are subject. Marx and Engels (1976/2001) were writing in a time of industrialization when the products in question were material. However, currently in the United States, we are in a post-industrial moment that is characterized by the manipulation of information and service providers (Hardt and Negri, 2000/2007). Industrial industries have been replaced by information and service industries; thus, those who are in control of systemic ideologies are those who control the means of information management and of service production. Health care, like other types of services, is a reflection of ruling powers ideologies to which the masses adhere, but which benefit the elite and not the average citizen.

Of concern to this particular project, is the means by which ideology regarding bodies and how value is placed upon the body is (re)formulated and (re)produced on the health website WebMD through the discourse of race and health care. A common way that bodies are marked as different in the United States is by race. It is commonly accepted by scholars that race is socially constructed (Omi and Winant, 1994; Williams, 1997; Lipitz, 2006); however, this does not mean that race is not “real.” Race “signifies and symbolizes social conflicts and interests by referring to different types of human bodies” (Omi and Winant, 1994). By maintaining and articulating difference, race functions to not merely signify difference but to also structure inequality (Omi and Winant, 1994). In the post civil-rights United States, racial inequality is most often maintained through “practices that are subtle, institutional, and apparently nonracial” (Bonilla-Silva, 2010) rather than through overt language and practices that are reminiscent of Jim Crow racism. This “new racism” is the same as older forms in that it requires an acceptance of white supremacist ideology. In the United States, White is the unmarked racial category and difference is determined in its relationship to Whiteness. Racial difference is not merely

categorized but value is placed upon those differences. Value is decreed in a way that places the most value on the category that is used for comparison and those categories, which are not the maintenance category, are inferior. Thus the definition of race is rooted in the notion that the Black body and mind is inferior to the White body and to maintain definitions of race the Black body must remain different and inferior to the White body.

Health and Health Care Disparities

The desire to focus on the mythic average American as previously described in the health care debate in the United States as shown in the aforementioned *New York Times* article becomes interesting when considering that the questions the journalist is posing are, will this mythic average American be cared for – will this White middle class male body be cared for after health care reform is in place? Health care generally, and health care reform specifically, has become a central political issue in the United States. Health care is not only of political interest; it is also an interesting site for the exploration of how different bodies are valued. Health care concerns how bodies are valued in concrete monetary terms because of the cost of health care. It also relates to how bodies are valued because it considers how the materiality of a body is maintained. In other words it concerns which bodies are important in terms of mere existence, since quality health care will extend the time that a body exists. These questions can be partly answered by looking at health and health care disparities as they have existed historically, as well as how health and health care disparities exist in the current social moment.

Health disparities are broadly defined as differences between prevalence and mortality of diseases and other health conditions that exist among different populations (Braveman, 2006). Examples of standard measures of health disparities that are used are infant mortality, incidences of cardiovascular disease and stroke, diabetes and HIV/AIDS. The term “health care disparities”

refers to the difference in access to and quality of health care available to different populations. Common measures of health care disparities are disease (e.g. cancer, diabetes, HIV/AIDS) screening and management, immunization levels, access to health insurance, and usual source of care (Braveman, 2006). A wealth of scholarship exists about health care as it relates to racial disparities. I have chosen to concentrate on health care research that focuses on the transmission of health information, health disparities, and health care disparities. Literature that focuses on the transmission of health information considers the way that knowledge about health and health care is transmitted to patients. The most common ways health information is transmitted are through patient-provider interactions and mass media health campaigns.²

Patient-provider interactions often occur as a one-way flow of information in which the physician is the knowledge keeper who passes information to the patient. In this regard, the physician becomes a type of gatekeeper of knowledge because it is the physician who determines what information is relevant to the patient. One of the things that is problematic about the one-way flow of information from the physician to the patients is that it does not take into consideration the “patients’ beliefs, concerns and preferences” (Stevenson et al., 2004, p. 236). Newer models of physician and patient interactions offer a cooperative relationship in which physicians and patients act as a partnership. A two-way communication partnership model of physician and patient interaction has the potential to empower patients and includes them in the process of making decisions regarding their health care, however, the degree to which this occurs varies depending on the patient. The inclusion of patients in their health care decisions is a fundamental argument behind the Health 2.0 movement. Marina Levina (2012a) argues that the

² For the purposes of this research, mass media forms such as television, print, and radio are not being considered. Instead the focus will be on the Internet. For examples of work on health information in the mass media in the forms previously mentioned see Corcoran (2007); Curry, Jarosch, Pacholok (2005); Duerksen et al. (2005); Lyles (2002); Mastin et al. (2007); Montagne (2001); Wilkes, Bell, Kravitz (2000).

Health 2.0 movement is characterized by “a growing effort to marry Web 2.0 technology, participatory discourse, and network subjectivity to health care and management.” (p. 143)

Integrating Web 2.0 technologies into patients health care practices allows for the promotion of “collaboration between patients, their care givers, medical professionals, and other stakeholders.” (Sarasohn-Kahn, 2008, p. 2)

The degree to which patient care is collaboration versus one-way communication of health information in the Health 2.0 movement is yet to be seen. It is also important to note that the idea of patient and provider interactions that are collaborative rather than paternalistic is not new. For example, as early as the mid-1950s researchers suggested that the degree to which patients are passive recipients of physicians’ information varies based on the severity of the disease and the invasiveness of the procedure necessary for treatment (Heritage and Maynard, 2006). It is important to note that the degree that patients are involved in medical decisions is significant, however, for the purposes of this project, I am mainly concerned about the physician being able to act as gatekeeper to health knowledge at all rather than to what degree this occurs.

The ability of health care professionals to determine what information a patient receives is what Stevenson et al. (2004) describes as “an asymmetrical relationship typical of paternalistic interactions” (p. 242). However, this “asymmetrical relationship” does not always occur in the same way or to the same degree. Interestingly the interactions between patients and health care providers has been found to be more equitable when the patient uses technical language or reveals in some other way their knowledge of the treatment or disease. Thus, by patients “proving” they hold a certain level of medical knowledge, they are more likely to have an equitable exchange with their health care provider (Stevenson et al., 2004). The fact that Stevenson et al. (2004) find that interactions between patients and health care providers is more

equitable when patients use medical jargon has interesting implications when considering which patients are receiving information and *how* they are receiving their information. Specifically, when patients are receiving their information from a health site like WebMD, they are limited to the information that the content creators on the site deem worthy. This finding that health care providers engage in more equitable interactions with patients who prove their health knowledge does not necessarily mean providers are consciously attempting to behave in a biased or paternalistic manner towards their patients. On the contrary, most providers who are given the option of receiving training to improve their communication with their patients chose to do so (Stevenson et al., 2004). The one-way model of health care in which a provider is the keeper of knowledge and the patient is the receiver of knowledge has a historical root. As noted by Heritage and Maynard (2006), historically doctors have been expected to “serenely dispense both medication and authoritative judgment” (p. 353). In other words, the health care providers responsibility is to remain detached and not interact on equal footing with their patients and it is within this tradition that most physicians have been trained. Now society is much more aware of the health care disparities and as such there is greater concern for rectifying these problems.

The interplay between technology and health care has been a hotbed of investigation in health care research (Bass, 2003; Neuhauser & Kreps, 2003; Suggs, 2006).³ There is often a desire to label technology as either “good” or “bad” however; technologies, individually and as an overarching conceptual grouping, are neither. When looking to analyze how the discourse surrounding race and health care intersect in cyberspace, the politics of the technology in use, the Internet, is important in terms of access. However, rather than attempting to parse out whether

³ For the purpose of this research technology refers to technologies that are used in the transmission of health knowledge and information such as the Internet. Technology in this instance does not include advances in medical technologies such as laparoscopic surgery.

the Internet is harmful or beneficial it would be more advantageous to examine what technologies and health care can tell us about hierarchical relationships in larger offline society and vice versa. For this project, I am specifically researching to see if health website can provide a reflection of health and health care in offline society as it relates to racial health and health care disparities.

Cyberspace and the Internet allow for transmission of information (generally speaking not necessarily only in regards to health care) in a way that is very different from previous communication technologies such as the telephone. The Internet has allowed patients to receive information through websites, message boards, and email. One way that the Internet has changed communication in health care specifically is that it allows information to be transferred between the patient and health care provider outside of a traditional medical setting. Providers and patients can communicate with each other through email (Leong et al., 2005; Moyer et al., 2002; Virji et al., 2006). The addition of this new form of communication can be beneficial in that both patients and providers are not limited by time and location constraints that are present in the scheduling of face to face interactions. Furthermore, it can be cost effective for providers and patients to communicate via email because patients will not have to pay for travel and an office visit when it is not necessary. However, email communication also removes important non-verbal communication between patient and provider. Non-verbal cues such as a patient grimacing from a touch or a sluggishness of mannerism might help a physician to draw conclusion about a patient's condition. These cues would be absent in an electronic communication such as an email.

What is perhaps more important than the altered communication between providers and patients is the fact that the Internet allows patients to more easily circumvent health care

providers all together. It is now possible for patients to use the Internet to gather health information without the help of a “professional.” In addition, information exchange from one patient to another in regards to health care is made easier through interactions such as chat rooms, email lists, and discussion boards in the rise of the Health 2.0 movement. Within the Health 2.0 movement “medical expertise is redefined as access and participation in web-based communities - a promotion of a networked utopia where health information is distributed and shared equally amongst all participants” (Levina, 2012a, p. 146). “[The] Internet is fast becoming the preferred method for easily connecting with others across boundaries to communicate, learn and expand opportunities;” (Mack, 2001, p. 89) so it is important to study the Internet as a source of health information for patients. If the Internet has become the preferred method to communicate and learn as Mack (2001) suggests, it is increasingly important to examine this space in which these interactions are taking place. Bass (2003) summarizes some of the potential implications for the increased importance of the Internet in patients gathering health care information:

The fact that consumers now have the same medical information that is currently available to providers has significant implications for the relationship between patient and provider. It alters the ways patients and providers communicate, and is helping to create a new consumer base of power in health policy and decision making. The Internet is also likely to shape personal perceptions of health and illness, patients’ compliance to treatment protocols and ultimately, overall health.

(p. 26)

The transmission of health care knowledge is also affected greatly by the framework of the US health care system and health care policies. In addition to scholars examining the transmission

of health information there are scholars seeking to interrogate health care policy and our current system of health care (Abraham, 1993; Budrys; Gordon; Mastin et al., 2007). During the 1970s, the emergence of the concept of the medical industrial complex appeared in scholarship (Brown, 1979; Klass, 1975; Relman, 1994; Waitzkin, 1978; Welter, 1977; Wohl, 1984). The medical industrial complex refers to the corporatization of the field of medicine. The corporate relationships within the health care system that define the medical industrial complex create and maintain larger systems of oppression. Rojas Durazo (2006) argues that the goals of the medical industrial complex “are to heighten profits, legitimate the state, and maintain the dominance of the western medical model, which, in turn, perpetuates racism, classism, and heterosexism” (p. 181). For the purposes of this dissertation, the way the medical industrial complex supports racial oppression is of the most interest. WebMD is an excellent site for the examination of the effects of the medical industrial complex because of the corporate relationships that are present. WebMD has partnerships with CVS drugstore to sell their products on the Internet, Eli Lilly to promote Prozac and other drugs on WebMD, and with Rupert Murdoch’s News Corporation to expand WebMD into overseas markets (“Our Services,” n.d.; Patsuris, 2001). These are a few of the examples that indicate that WebMD’s goal is to heighten profits regardless of the sociohistorical realities of racial health care disparities that are seen in offline environments.

Health care disparities illustrate how populations are treated differently under the current health care system in the United States. However, I would argue that an understanding of the differences in the way that bodies have been treated historically within the field of medicine can add to our understanding of current health care disparities. If we follow the historical trajectory of the use of bodies in medicine we can see the way value is placed upon the body in health care as well. One of the ways this is most clearly indicated is in the realm of human medical

experimentation. Human medical experimentation has been, for the most part, an acceptable part of the furthering of the realm of medical knowledge (Gamble, 1997; Hornblum, 1998; Jones, 1993; Washington, 2006). Human medical experimentation can be argued to be a necessary evil in which harm to one person has the potential to save many people. Those who are chosen to be subjects of medical experimentation were often people from groups who were oppressed in society. People who are subjected to these experiments are not considered to be valuable members of society. The devaluing of bodies is seen in the ways people who are used for medical experimentation are referred: they are “subjects.” They are rarely patients, and never people, but rather are turned into dehumanized subjects to be studied. People who have endured human medical experimentations have become nonhuman objects that are to be studied by their human researcher counterparts. Furthermore, I would argue that another repercussion of labeling people who are the subjects of medical experimentation is the creation of a human/nonhuman binary. By creating a binary in which one person is considered human (medical researcher) and the other is nonhuman (test subject) a power dynamic is also created. Medical experimentation specifically and the inferior treatment of black bodies in medicine historically can be seen as overt events that have shifted into more covert medical mistreatments over time. For example, historically legalized and de facto segregation excluded black bodies from medical care facilities. Over time as these practices became illegal and fell out of favor, there is still difference in the way black bodies are treated. As noted by van Ryn and Burke (2000) even when controlling for mitigating factors such as income, insurance status, and disease severity, physicians’ (un)intentional racial prejudices affect physicians’ treatment of their patients. Specifically, the authors found that physicians perceived black patients more negatively in regards to intelligence, risk behavior, and noncompliance (van Ryn and Burke, 2000). The covert mistreatments of black

bodies by health care providers potentially would have gone unnoticed if research had not unveiled health care disparities. The historic mistreatment of black bodies in medicine provides a context for current health care disparities, however, it also creates a framework for understanding that valuing bodies is not a new phenomenon, but one that has shifted into a more furtive form.

It is important to note that racial health care disparities are not just the result of individual providers' prejudices and unequal treatment. Racial health care disparities are also a result of systemic oppression. Within health care scholarship the effects of systemic oppression are largely seen in work that examines health and health care disparities. Scholarship on the ways race influences health care disparities often focuses on specific factors such as socioeconomic status of the patients or patient-physician interactions. In other words, research seeks to examine factors that can be measured quantitatively such as income, education level, and literacy (Kennedy et al., 2007). Alternately much research focuses on racism and discrimination that occurs in patient-physician interactions. However, the scholarship often lacks exploration of potential theoretical underpinning of racial health care disparities. For example, Satcher and Higginbotham (2008) consider how a public health approach can be used to help to eliminate racial health care disparities. A public health approach focuses on identifying and measuring the problems, determining risk factors, and creating and implementing strategies for reducing or eliminating the problem of racial health care disparities.

One study that interrogates the theoretical underpinnings of research in racial health care disparities was conducted by Lo and Stacey (2008). The authors examined recent calls for "cultural competency" in health care in the medical field. Cultural competency is defined by the US Department of Health and Human Services as "a set of congruent behaviors, attitudes, and

polices that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Office of Minority Health qtd. in White-Means et al., 2009, p. 441). Some research has suggested that cultural competency in health care is a means of reducing racial health care disparities (Betancourt et al., 2005). However, Lo and Stacey (2008) found that scholarship on cultural competency tends to be flawed in a significant way. Competency literature tends to work from the assumption of racial and ethnic groups as homogenous on one extreme to the other extreme that views culture as subjective to the point of rendering cultural competency guidelines impossible (Lo and Stacey, 2008, p. 743). The authors use the works of Bourdieu, specifically his concept of habitus, to address the interaction between culture, context, and social structures in the hope that considering cultural competency on the level of theory can help to reduce this tension. Habitus can be thought of as the way in which society develops expectations and values through their common experiences and everyday interactions. Thus individuals behave and act upon societal expectations, as they understand them. Bourdieu’s habitus allows for a more complex understanding of culture that accounts for a commonality within a group as well as allows for differentiation among individuals (Lo and Stacey, 2008, p. 745). The authors also draw from the works of Sewell. Sewell’s notion of the interaction of schemas and resources allows for flexibility in structures as well as the application of both old and new schemas (Lo and Stacey, 2008, p. 746). Sewell’s concept of schemas is more fluid and generalizable than Bourdieu’s concept of habitus, however, both theories give a framework for understanding that individual behavior is guided through social expectations. Furthermore, the social expectations that guide individuals’ behavior also (re)creates social structures including social institutions and institutional power. The work of Lo and Stacey (2008) highlights that

while there have been efforts to explore the causes of racial health care disparities, if the theoretical underpinning of said approach is flawed there will be little if any change.

Cyberspace

For the purposes of this research, cyberspace is the technology of interest. Cyberspace is often thought of in opposition to the “real world.” However, the Internet and cyberspace are far from being isolated from the physical world because “when it comes to questions of power, politics, and structural relations, cyberspace is as real as it gets” (Kolko et al. 2000, p. 4). “The days in which *Wired* magazine and *Mondo 2000* set the agenda for an elite and largely male digerati have passed,” according to Lisa Nakamura (2002, p. 1). The Internet has moved from niche culture to firmly take its place within everyday life. This shift is arguably one of the most important technological developments in recent history. Information exchange is faster and cheaper than before. People on opposite sides of the globe or across town can communicate in the same amount of time for about the same monetary cost.

Much like physical space, cyberspace influences how people are able to engage in information exchange. In the US access to the Internet is almost universal; however, there exists a class divide in how people access the Internet. If a person only has Internet access in public locations, such as at their workplace or at the public library, their experiences on the Internet will be different than that of people who have Internet access at home. Deborah Lupton (1995) speaks of how users’ embodied relationship to personal computers blurs the line of the computer/user dyad. She argues that “users invest certain aspects of themselves and their cultures when ‘making sense’ of their computers, and their use of computers may be viewed as contributing to individuals’ images and experiences of their selves and their bodies” (Lupton, 1995, p. 99). The degree to which users are able to invest into their computer, specifically, into

consuming a particular website is mitigated by the location in which they are accessing the computer. Accessing the Internet in a public space, such as at the workplace, will not allow a person to invest themselves into the Internet as fully as someone who is accessing the Internet in the privacy of their home during their leisure time.

Of particular interest in the following project is how race is articulated in cyberspace. Visual markers of race appear in cyberspace, yet it often occurs as racially segregated spaces, be it whitewashed spaces such as described by McPherson (2000) or in spaces that allow agency for racially digitally marginalized groups such as BlackPlanet.com as described by Banks (2006) that inadvertently renders race silent; thus, it is presumed that race is absent. The silence of race denotes the lack of overt articulations of race, not that race does not exist because in a society that is largely defined by race, race is never truly silent. Information about race is translated in cyberspace in ways that are similar to the transmission of “racial common sense” in offline environments. Omi and Winant (1994) describe the way racial common sense occurs and is maintained in the US:

Everybody learns some combination, some version of the rules of racial classification, and of her own racial identity, often without obvious teaching or conscious inculcation. Thus are we inserted in a comprehensively racialized social structure. Race becomes “common sense” – a way of comprehending, explaining, and acting in the world. (p. 60)

Race, whether overt or in a silent form, is important in cyberspace “because all of us who spend time online are already shaped by the ways in which race matters offline, and we can’t help but bring our own knowledge, experiences, and values with us when we log on” (Kolko et al, 2000,

p. 5). In other words, the patterns of race and race interactions in cyberspace mimic those that occur in offline environments.

Since offline environments mimic online environments, it stands to reason that health disparities that are present offline will also be present online. However, this is not necessarily relevant if people are not using the Internet to gather health information. The Internet is a source of everyday information, but is the Internet being used as a source for gathering information that is not necessarily “general” such as health care? Early research suggests that people do use the Internet to gather health information (Bass, 2003; McLellan and Friedman, 2004; Miller and West, 2009). The degree to which patients use the Internet to gather health information is not agreed upon among scholars; however, I would argue that the fact that the Internet is used by patients at all is relevant and requires further study. Because of the constant change and growth of the Internet, cyberspace, as well as people’s means of navigating the Internet, it is impossible for any researcher to conclude definitively that patients use the Internet to a significant amount. Furthermore, what constitutes a significant amount will vary amongst researchers and scholars depending on the goals of their research. Ultimately, the fact that anyone uses the Internet to gain health care information is significant because it shifts the power of the knowledge keeper from lying solely in the hands of the physician. Thus, the physician is no longer the only gatekeeper of medical information and knowledge. However, the keepers of medical information do not rest only within the patients either. In cyberspace, physicians, patients, and corporations all act as knowledge gatekeepers to varying degree.

The concept of medical professionals as gatekeepers of medical knowledge is discussed in an interesting way by Foucault in his work *Birth of the Clinic* (1963/1994). In his text, Foucault (1963/1994) argues that medical professionals are trained in performing the “medical

gaze.” The medical gaze is a method by which medical professionals learn to look upon a patient and know what “sick” and “diseased” looks like compared to a healthy body. Thus, physicians are in a position of power to create medical knowledge through the medical gaze (Foucault, 1963/1994). Foucault (1963/1994) goes further to argue that when looking historically at medical knowledge, one can conclude that illness and disease in some cases is arbitrary and socially rooted. In other words, a body is considered sick because the medical community, influenced by societies ideologies, has determined it to be so not because there is something physically wrong with the body. Considering Foucault’s concept of the medical gaze raises the question of does the existence of health websites call into question who is trained in the medical gaze? It could be argued that WebMD allows a patient to bypass the physician’s gaze to become the person who performs the medical gaze. As such, in a sense, the patient becomes a gatekeeper of medical knowledge because he or she becomes trained in the art of the medical gaze. Furthermore, WebMD as a corporation acts as a gatekeeper as well because it ultimately determines what content is available to the site users. Therefore, the corporation also becomes a creator of the medical gaze. The ability of patients and corporation to look upon a body or a rendering of a body that is diseased changes the practice of medical information and knowledge being kept and distributed only by trained medical professionals. Instead physicians, patients, and the corporation are controlling the information flow of medical information.

Methodology

As previously stated, this project seeks to be an exploration of whether or not bodies are valued. Additionally, if bodies are valued, how is value placed upon bodies? In attempting to come to a conclusion about the larger question of how value is placed on bodies, this project will concentrate on how bodies are racially (re)presented on the health care website WebMD. The

following research questions will guide this dissertation: How can a textual analysis of WebMD reveal rhetorical practices that (re)create power in the discourse of race? How can an examination of WebMD through visual cultural analysis illuminate how health care knowledge is formed and reproduced by the consumers of the website? What does how race is (re)presented on WebMD illustrate about which bodies are valued in health care? How, if at all, do how bodies are valued on WebMD reflect racial ideology in larger society?

To answer these questions I will utilize methods from visual culture studies and textual analysis. The particular combination of using textual analysis and visual analysis is the most beneficial for this project because it allows for the analysis of the images that are present on the website as well as an analysis of rhetorical practices. The first level of analysis of WebMD through textual analysis and through visual culture analysis provides a framework that allows for the examination of images that are present on WebMD as well an analysis of rhetorical practices that occur through authorship and audience. However, it is largely comprised of discourse analysis. Foucault is most often credited with the concept of discourse. Discourse analysis allows for the exploration of how knowledge is produced. Furthermore, it can illuminate the relationship between knowledge and power. Specifically, the creation and maintenance of particular discourses is means of controlling knowledge formation that in turn is a means of maintaining power within a society.

Visual culture studies provides a method of analyzing the way the Internet (re)produces images of the self and the body “in the context of racial and gender identity formation” (Nakamura, 2002, p. 5). Visual culture analysis provides a means of articulating power and resistance dynamics that are present in imaging racial identities. The previous work of visual culture studies that constitutes focus on the gaze, especially works of the postcolonial gaze and

male gaze, have the potential for aiding in constructing a framework from which digital images of the Internet can be examined. Nakamura (2002) argues that the Internet is the epicenter for discursive (re)creation of racial images and imagining even though that is not the overt goal. The use of visual culture studies to examine the Internet in general and WebMD specifically holds promise as a methodology because like images in art and motion pictures, websites provide digital imagery that is no less “real” than previous pictorial forms. As Nakamura (2002) states, “[D]igital objects, [. . .] do possess distinctive cultures of bodily representation, flow, privacy, identity, and circulation and have created unique communicative and institutional contexts.” (p. 13). Visual culture studies complicated John Berger's (1990) concept of the gaze made popular in his work *Ways of Seeing*, in which "the subject is defined as that which views, and the object as that which submits or is subjected to the gaze" (qtd in Nakamura, 2002, p. 16). The object-subject relationship as defined in Berger's concept of the gaze becomes complicated in new media because it is not always possible to separate the subject from the object, the viewer and viewed, artist and model, website consumer and website producer. Thus a website such as WebMD cannot be examined in terms of an easily identifiable producer and the easily identifiable consumer. The consumers of WebMD are partially producers as well. For example, as consumers click through various pages they are creating a specific series of objects to be consumed in a specific sequence of their choosing, unlike a film in which a director makes those decisions for the consumer.

In addition to visual culture studies, textual analysis can help to flesh out the fluid relationship between the subject and object in cyberspace. Textual analysis allows for the examination of the rhetorical practices that are being employed on WebMD. Through textual analysis, I will be able to speculate on the intent of the authors and potential results that are

consumed by viewers of WebMD. For this project, I will use textual analysis to determine the frequency of the appearance of black bodies in specific areas of WebMD. The frequency of language associated with race will be determined, including overt and covert references. The same pages will be analyzed using visual culture analysis. The images as well as the page layout will be considered as part of the visual field that is being studied. In addition, authorship of the pages and the means of accessing the subpages will be considered as part of determining the malleable authorship of the website.

The crux of the following analysis will be the use of discourse analysis. At the core of discourse analysis is the relationship between power and knowledge formation. Nakamura (2002) argues that the Internet is the epicenter for discursive (re)creation of racial images and imagining even though that is not the overt goal of the Internet. However, it is also important to consider historical contexts of knowledge formation. It is important to consider the historical context of the use of the Internet by patients to research health care. The relevance of WebMD should also be examined in terms of the place of Internet technology generally speaking as well as the effect of technology's effect on medicine and health care. The Internet is by no means the first type of technology to affect health care. For example, x-rays and computers in general, have contributed to a change in medical knowledge, the patient-physician interaction, and health care (Howell, 2004). Moreover, technologies that do not appear to have a direct effect on the medical field and health care in fact greatly transform medical knowledge and practices. For example, the typewriter increased the speed and accuracy that information could be recorded. Thus the typewriter was a way that information could be comprehended more effectively. With a standardized mechanical system of producing the written word, there is not the potential for misreading handwritten material (Howell, 2004). Therefore, it is important when using

discourse analysis to also consider the sociohistorical context of said analysis to truly understand the context of power and knowledge creation. Thus knowing the historical relationship of technology and medicine is important. It is also important to consider the historical context of the black body in medicine. For example, the use of the black body in medical experimentations, such as the Tuskegee syphilis experiments, sets a historical stage for modern mistreatment/maltreatment of the black body (Washington, 2006).

The analysis of WebMD will include textual analysis, visual culture analysis, and discourse analysis. The homepage of WebMD will be the initial site of exploration since all user will first encounter that space. In addition to analyzing the homepage, I have chosen to analyze disease subpages. I have chosen to examine the diabetes homepage and the HIV homepage. These two particular disease subpages are of interest for several reasons. First, both diseases are high causes of mortality for Blacks. However, the diseases develop in different ways. Diabetes has some genetic components but it is also partly a result of nutrition and wellness. HIV however is a disease of contagion that is a result of immediate one time activity. The different nature of these two diseases covers similar aspects of other diseases that are typically used as measures for health disparities. Analysis of the homepage and disease subpages will be conducted on a random basis in an attempt to mimic the way an actual user would access a health website such as WebMD. Examining the pages of interests in a standard pattern, such as every Monday at 6pm for example, might represent the way that some users engage with the website; however, it is more likely that user access WebMD when they have a specific medical question of concern.

Conclusion

Any discussion of the category of race invariably will be influenced by the intersectional nature of identifying categories such as gender, class, sexuality and region, yet this particular project will not consider these categories as fully as race will be examined. The absence of other representations of people of color other than Black people within this research project – Asian, Latino, Indigenous – is also noteworthy. I have chosen to focus on the representation of the Black body because, while the Black body is not represented to the extent of the White body on WebMD, it is more substantial represented than that of other racial groups. The goal of this project is to examine the ways that racial health and health care disparities offline are mimicked in online environments. To do this, I will examine the homepage, diabetes, and HIV/AIDS subsections of WebMD.com. As a means of comparison, I will also examine the homepages, diabetes, and HIV/AIDS subsections of the Mayo Clinic's website and the Center for Disease Control's website.

Chapter 2 contains the literature review section of this dissertation which defines various terminology and concepts that are often misunderstood or misused in talking about health care and race. For example, health disparities and health care disparities are sometimes used interchangeably by laypersons; however, these terms have different meanings, as described previously in this chapter, even though those meanings are interrelated. Similarly, race, racial ideology, and racial structure also have different but interrelated meanings. In addition, this chapter will provide a historical context for understanding technology in general and cyberspace and the Internet specifically, including early hopes and subsequent failures at achieving said hopes for the Internet. In addition, Chapter 2 will provide an overview of research findings regarding racial health and health care disparities offline. Chapter 3 details the methodology

used for this project. Specifically, I will address the difficulties of researching a moving and changing subject such as the Internet. In addition I examine the discursive power of race and health care in cyberspace as it relates to the offline environment and the online environment. This chapter will explain the ways that I utilize the works of Butler and Foucault to outline a theoretical framework for this dissertation. The work of Butler that examines the discursive limits of sex can be used to examine the discursive limits of race. Foucault's work on the discourse of medicine will establish how knowledge, privilege, and power are created through the discourse of health care. Chapter 4 includes the analysis of WebMD, the Mayo Clinic's website, and the Center for Disease Control's website. I will explore how race and health care is articulated on these health websites. It is important to consider how the use of the Internet by patients transmutes doctor-patient interactions, specifically the transmission of medical and health information. In choosing to conduct a textual analysis of WebMD, it is my goal to parse out what the cyberbodies of the website are able to tell us about who corporations and authors are gearing health and wellness information towards. This chapter will also be comprised of a visual cultural analysis of WebMD. A visual culture analysis of WebMD will allow for the consideration of a form of the medical gaze that is both developed and used by consumers of WebMD. This will be an opportunity to also consider the creators and contributors to WebMD and how they affect the medical gaze of the consumers.

Chapter 5 articulates why the discourse of health and health care is a reflection racial ideologies that are rooted in white privilege and new racism that is present offline in institutional hierarchies. In doing so, the site is also articulating who is worthy of a healthy body and thus who is worthy of life. In showing whose bodies should be healthy vital bodies, the absence of other types of bodies reinforces the subordinate position that is conferred upon those bodies. As

Herman S. Gray (2005) notes, “new communication technologies actually get inscribed and articulated by social relations and logics that produce greater exploitation, domination, and inequality” (p. 134). Thus the discourses that are present on health websites like WebMD are a technological reflection of racial discourses, or techno-racial discourses, which are already established offline. This concluding chapter also provides an opportunity to posit the future of race and health care in cyberspace.

The main question guiding this dissertation is how bodies are valued based on racial ideologies in terms of health care. It is important to note that while ideologies are largely formed by people and groups who are in power, ideologies cannot be maintained without the support of the larger general population. It is easy to discount strong opposition from outlandish parties. However, inequalities cannot be maintained through enforcement by a handful of people. It is necessary for there to be consensus among many to maintain systems of oppression. Thus the examination of WebMD is important because it is a site where a powerful minority – medical professionals – is being replaced by the general public as the group that is the holders of health care information and knowledge in the form of the Health 2.0 movement. It is also the general public that consumes WebMD that is recreating health care knowledge.

This dissertation falls at the nexus of race in cyberspace and of health care in cyberspace. WebMD provides an ideal location for this examination. The World Health Organization’s 2000 *World Health Report* focuses on health systems of the 191 member nations. The report ranks the US as first in health care expenditure but ranks it thirty-seventh in overall health performance (World Health Organization, 2000). I would argue that this is an indication not only of mismanagement of resources but also of a stratified distribution of resources that is a reflection of a white supremacist patriarchal capitalist system. As such, it is imperative that health care

scholarship continues to develop understandings of not only illuminating health care disparities, but also work towards identifying theoretical schemas that are governing the perpetuation of health care disparities. Humanities, generally, and cultural studies specifically, has much to contribute to the field of health care research.

“I am face-to-face with my computer for far longer than I look into any human face.” – Deborah Lupton, The Embodied Computer/User

CHAPTER 2: REVIEW OF LITERATURE

When examining the Internet, it is important to think of it as more than just a technology. We must also consider technology in terms of how people use it and how it unintentionally functions. On the surface, the Internet is merely a technology that allows people to gather and exchange information and ideas. As Sherry Turkle (2011) notes, in its early inception, the Internet’s ability to connect people together was the great hope; the Internet would democratize communication and information exchange. The Internet made it possible for people now to connect to hundreds, even thousands of people from all over the world and engage with each other, exchanging information and ideas. However, even though the Internet is a place where people can exchange information and communicate more readily, the Internet is also a creator of a geopolitical space in which power relationships are forged; cyberspace is that geopolitical space. Even though cyberspace is technically infinite and indefinable in terms of its borders that does not mean that cyberspace can easily be characterized as having one central hegemonic ideology. Ideological frameworks that originate with users in offline environments are transferred into cyberspace. These ideologies that users have brought into cyberspace then (re)create the ideological frameworks that guide the landscape of cyberspace (McPherson, 2000; Nakamura, 2002; Dodge and Kitchin, 2007). Undergirding the ideologies that are present in cyberspace are the creation and maintenance of power relationships that begin offline. It is difficult to think of cyberspace as a place where power dynamics and relationships are taking place partly because cyberspace has become an everyday commonality. The Internet and cyberspace has integrated into our (sub)consciousness to the point of invisibility. However, the

silence of invisibility need not be seen as a reason to minimize or ignore the relevance and impact of cyberspace.

As noted by scholars such as McPherson (2000), Nakamura (2002), Everett (2009), Boyd (2011), and Graham (2013), cyberspace is influenced by offline social structures and institutions. While time and space is compressed and made nonlinear in cyberspace – which is a sharp departure from offline environments – there are great similarities between cyberspace and offline to the point where it can be argued that cyberspace in many ways effectively mimics offline environments (McPherson, 2000; Nakamura, 2002). Of interest to this research project are the ways that structural and institutionalized racism that is present offline in the social institution of health care is continued through cyberspace into modern elements of health care, mainly, through health websites such as WebMD.com. To effectively examine the way that cyberspace mimics offline realities in terms of structural and institutionalized racism that is presented in health care, we must examine the ways that cyberspace is not only used but also how it (un)intentionally functions in larger society and in terms of health care.

Technology/Cyberspace

In the mid 1980s Langdon Winner (1986) made the argument for considering technology in terms of two things: making and use. For the purposes of this research, I am mainly concerned with the use of WebMD, however, it is important to note that the “making” of WebMD, i.e. the formation and (re)creation of the website, is not irrelevant to the concept of its use. The terms Internet and cyberspace are often used interchangeably; however, the two can be thought of as two distinct entities. “Internet” refers to the physical mechanisms, innovations, and processes that come together to form cyberspace. Cyberspace can be thought of as a geographic location much like a city, state, or nation. Unlike the boundaries that separate nation states, cyberspace

theoretically has infinite reach and possibility. However, the metaphor of cyberspace as a geographic location has limited the infinite nature and potential of cyberspace. Instead, as noted by Graham (2013), the metaphor of cyberspace as a geographic location “constrains, enables and structures very distinct ways of imaging the interactions between people, information, code and machines through digital networks” (p. 177). In other words, embedded in the discourse surrounding and about the Internet and cyberspace, we have (un)intentionally constrained the possibilities of differences from offline environments from developing. In thinking of cyberspace as a geographic place similar to offline environments, we have encouraged the discourse of cyberspace to mimic offline realities. Graham goes on to argue “the Internet has been shown to have distinct spatial biases that greatly influence possibilities for voice, representation and communication that are mediated through the network” (2013, p. 179). Thus cyberspace mimics offline institutional hierarchies and power dynamics within social structures that trickled down into influencing individual’s interactions; leaving those hierarchies to continue in cyberspace. However, it is important to note that the relationship between offline and online environments is not simply a discursive one.

Winner (1986) provides a compelling argument suggesting that the ways that we as a society, as well as individuals, work, communicate, and consume via technology is influenced by a person’s position within hierarchical relationships offline. “If the experience of modern society shows us anything, however, it is that technologies are not merely aids to human activity, but also powerful forces acting to reshape that activity and its meaning”, writes Winner (1986, p. 6). Thus something that on the surface that seems inconsequential, in this instance traversing cyberspace, in reality is deeply rooted in societal hierarchies. The institutional hierarchies that exist in society are partly influenced by how we learn. Knowing how to effectively engage with

technology and how to use it in the ways suggested by Winner (1986) is a learned skill. As noted by Mossberger et al. (2006), the work environment acts as a means for people to learn technology skills. More importantly, the authors suggest that employment can act as a gateway to learning and using technology that eventually leads to individuals purchasing computers for their homes (Mossberger et al. 2006). When considering class levels, those in low paying, low skilled jobs will have less exposure to technology and thus are also less likely to acquire computers and other forms of technology at home (Mossberger et al. 2006). In addition, people's relationship to technology is also unequal in how deeply integrated a person becomes with technology. The level of integration with technology that an individual experiences can be thought of as awareness of the technology's place within society, as well as, a reflection of the person's place in society (Winner, 1986). For example, a person's ability to access technology is a reflection of that person's socioeconomic placement within a given society. The cost of hardware limits access to certain technologies for those who are in lower economic classes, thus making it more difficult for people in lower socioeconomic groups to be able to interact with others in cyberspace because they lack the hardware or access to hardware that would allow them engage with other people in cyberspace. Regardless of some limitations, engaging with a computer and with others via cyber technology has become a ubiquitous part of daily life in the modern era (Lupton, 1995; Nakamura, 2002; Elwell, 2014). Therefore, a person who is unable to afford to have a computer and/or Internet access at home will be limited in the amount of time that they can engage with others online and are able to gather information. The people that are cut out of the ability to fully integrate with cyberspace are being left behind and institutional hierarchies are able to continue. Furthermore as noted by Nakamura (2002) not being able to

access the Internet makes it easier to eliminate certain bodies from the histories of a society because they are simply not present to the same degree as those in positions of power.

The Internet works in a way that helps to maintain a form of order and normalcy to our everyday world. Technology allows for the users to determine what is most important in their lives and everyday activities. However, I would argue that technology creating order and normalcy does not necessarily mean that people use technology to isolate and engage with the things that are most important to their lives and well being. Furthermore, we do not always make conscious decisions as to what is “most important” when engaging with technology. An individual might check a social media site such as Facebook on their phone as a means to past time or out of boredom. However, I would argue that when people engage with Web 2.0 technologies they are unconsciously marking their family, friends, coworkers, and other associates as important because they are taking time and effort to engage with people in their lives through technology. The same can be said for people consciously or unconsciously navigating to and engaging with various websites. In the case of WebMD, people engaging with health care websites seem to be concerned with their health and wellbeing. The importance of making the impression that one is concerned with their health in the modern era should not be ignored. There is a certain level of privilege associated with having the luxury of having the time to engaging with health websites such as WebMD or other technologies that can assist with daily living for that matter.

Technology in general and cyberspace in particular changes the way people interact with each other to the point that the “construction of a technical system that involves human beings as operating parts brings a reconstruction of social roles and relationships” (Winner, 1986, p. 11). When thinking about those social relationships and (re)construction of social roles that Winner

alludes to as they relate to WebMD, it is important to note the evolution of the physical technologies that allow people to access the Internet. In the begins of consumer Internet use, to be able to access cyberspace people would need to be connected to a piece of machinery that was physically connected to a hardwired Internet line. Thus people were physically limited to where and when they were able to use the Internet. Tethered systems of connecting to the Internet evolved to include wireless networks and systems, so people have gained freedom from the limitations of hardwired Internet. In addition, the invention and evolution of smartphones allows consumers to use the Internet virtually anywhere at anytime. The anywhere/anytime nature of connecting to the Internet is truer for people that have multiple Internet access points. Therefore, an elderly person, for example, living in a rural area is less likely to access the Internet regularly compared to a middle aged person who holds a white-collar job, owns a smart phone and a home computer. The proliferation of smartphones means that the scope of where and when people can access the Internet has grown significantly. Furthermore, some research shows that those that access the Internet via smartphone are much more likely to be people of color (Anderson, 2015). While this does have an effect on the digital divide in terms of access, it is important to note that, while smartphones do provide access to the Internet, as of this writing, smartphones also have limited capabilities when compared to laptop and desktop computers. Therefore, even though smartphone are helping people in less privileged categories access the Internet when they could not do so before, there is still a difference in ability to use the Internet fully between difference categories of people. Furthermore, of particular interest to this project, the percentage of smartphone owners that use their phones to access health information is higher among Blacks and Hispanics compared to White smartphone owners (Anderson, 2015). Thus, if a health website has limited mobile functionality that will also limit the amount of information a person is

able to receive. Therefore, people of color who use their smart phones to access health information would be at a disadvantage compared to people access health website via a laptop or desktop computer.

Early thoughts about the relationship between the user and cyberspace argued for the idea of cyberspace as a location where users can disconnect from themselves and their bodies. This concept of disconnecting from oneself was famously depicted in a cartoon in *The New Yorker*, in which a dog sits at a computer with the caption, “On the Internet, nobody knows you’re a dog.” However, as early as the mid-1990s, scholars began to question the notion of disembodiment and instead shifted to thinking of the Internet as an extension of its user (Lupton, 1995; Elwell, 2015). At this point, the line between the human user and the geography of cyberspace has been blurred beyond separation. The way people interact act with their computers requires a certain level of anthropomorphism that is not present in relationships with other technological objects. Deborah Lupton (1995) uses the term psychotopography to describe the relationship that people have with their computers. Psychotopography refers to the process by which the boundaries between self and machine often become undefined. The machine becomes an extension of the human. The human blends with the machine such that this relationship between human and machine ultimately leads to shifts in the way people navigate the world both in and outside of cyberspace (Lupton, 1995). Lupton (1995) goes on to argue that the merging of the body and the computer (which can be interpreted as a “brain”) is the ideal example of a Post-Enlightenment reality. The hope of Enlightenment utopia is a separation of the mind and the body. The postmodern state of computer (brain) and human (body) interaction thus is the antithesis of the Enlightenment utopia. The merging of the body and the computer leads to the feeling of a computer that is human. In this way, the Internet as well becomes an extension of human beings.

The focus of this research project is the user that on the surface could be called “casual” but who in fact relies on computers and computer technology as a necessary part of life. The need for these technologies is so pervasive it has become invisible to the average user. Cyberspace as a place to gather information is a concept that has been normalized into invisibility and that invisibility leads to silence. Lupton (1995) articulates that computers are often advertised by companies to emphasize the (non-existent) human characteristics of the machine, implying that computers have emotions and potentially even a soul. I would argue that websites tend to take this a step further to engage the users in a way that gives breath and life to the inanimate world of cyberspace. In fact, that mere reality of changing and morphing of the Internet and cyberspace is indicative of a person who grows and changes overtime, both physically and mentally.

Furthermore, the elusive nature of something such as a “soul” - something that is hard to define and even harder to place - is very similar to cyberspace: where does it begin or end if it has a beginning or end at all? Indeed, the relationship between technology and the user creates a somewhat ambivalent experience. This ambivalence is even more pronounced by the relationship between computers, the Internet, and the user. The ambivalent computer-human relationship, on one hand, has become something that has integrated so thoroughly into users’ lives that I would argue that the sudden absence of the Internet could most likely lead to confusion and anxiety.

One way in which the shifting of boundaries between machine and human is seen that is of greatest importance to this current project is the relationship between human and machine in the information gathering systems. It is not uncommon for people to now find information by first going straight to the computer, specifically entering cyberspace to use the Internet as a means of seeking knowledge about a subject. Since cyberspace is largely an unconfined space

and lacks regulation and oversight, it functions in a way that spaces such as libraries cannot. For example, the holdings within a library are usually determined by several people. In addition, the public can only access libraries at certain times, days, and locations. Once in a library, patrons must follow rules of conduct and rules and regulations for accessing information. The Internet, however, lacks that structure. People can access the Internet at anytime and anyplace with the proper connection. Anyone who chooses to do so and has the knowledge of how to do so can post information to the Internet. The accuracy and validity of that information is not regulated before the public is allowed to access it. This lack of regulation and oversight means that for the most part any information on the Internet is “valid.”⁴ Therefore, information – knowledge of subjects and topics of any type – can be (re)created multiple times regardless of its accuracy or truthfulness. This lack of oversight is interesting in the case of health websites such as WebMD particularly because misinformation about health and health care can lead to worse care or in extreme cases even death. Furthermore, social ills such as institutionalized racial inequalities can be carried from offline to online environments for users to consume if the creators of the websites are not invested in actively combating known inequalities. Information that is steeped in institutionalized racism is then passed on to the consumer of the website.

⁴ Indeed the importance of cyberspace as a location of knowledge gathering and the lack of regulation of information can be seen in the increase focus on “information literacy” in college and university settings. It is not uncommon for courses to include as a learning objective, similar to critical thinking or written communication skills, information literacy or the ability to discern what is quality information on the Internet and how to use information from the Internet. In addition, the need for sites such as snopes.com to verify if information is truthful and/or accurate is a reflection of how much bad information is available in cyberspace.

Health and Cyberspace

The fact that former President Bush signed an executive order creating the position of National Coordinator for Health Information Technology points to the importance and changing nature of the relationship between health and technology.⁵ The creation of this position by former President Bush is significant to the new health care reality of patients relying on the Internet to mitigate rising health care costs (West and Miller, 2009).⁶ Even with new government focus on Internet health care, multiple stakeholders must work in conjunction for the successful implementation and use of health care in cyberspace. In terms of health care, major stakeholders include patients, caretakers, health care providers, pharmaceutical companies, insurance companies, and hospitals. When we consider how many different entities have interest in Internet health care, it becomes increasingly clear that meeting the best interests of all parties involved is a daunting task. The term e-health has been used to describe the use of the Internet and related communication technologies to aid in physician and patient interactions and health care (Neuhauser and Kreps, 2003). This definition of e-health initially seems broad and somewhat vague. However, it is an accurate description of the multitude of ways health care and health communication has changed since the Internet became widely used. E-health comprises a

⁵ The National Coordinator for Health Information Technology is charged with “devising medical policies that use technology to improve health care quality, reduce costs, and coordinate medical care among different medical professionals” (West and Miller, 2009, p. 6). The physician is part of the Office of the National Coordinator for Health Information Technology, which is a division of the US Department of Health and Human Services. The office’s initiatives include cyber security creation of nationwide health information network standards and practices improving rural health technology infrastructures and providing support for healthcare professionals in the use of information technology and health.

⁶ It should also be noted that during the 2008 presidential election Hillary Clinton and Barack Obama both argued for an increase in the use of electronic technologies to improve healthcare quality and affordability. In addition Newt Gingrich also called for the use of electronic technologies in healthcare and to improve efficiency and cost. The bipartisan support of the use of technologies and Internet help clearly indicate a shift in healthcare in the United States.

large array of systems that include both for-profit and government websites, communication with health care professionals via e-mail and web messaging, appointment scheduling, prescription renewals, doctor referrals, digital diagnostic systems, and to a lesser extent telemedicine (Miller and West, 2009). Quoting Helen Hughes Evans, West and Miller (2009) argue “technology has stripped medicine of its humanistic qualities” (p. 2). However, I would argue that is it not technology per se, rather is it the ideologies about health care and who should receive quality care that are actually being amplified because now those belief systems are being observed both offline and online. Furthermore, the problem with the use of technology in health care is not the technology itself but more so the political and socioeconomic challenges and barriers associated with adopting digital technologies in health care. In fact, research has shown that e-health has the potential to improve provider patient relationships as well as put patients in contact with others who are experiencing the same disorders and diseases as they are (West and Miller, 2009).

Although e-health comprises several different types of computer and Internet mediated health interactions, this project focuses on health websites specifically. When looking at for-profit health websites, such as WebMD, the websites will need to meet the interests of all their respective stakeholders because ultimately it is a corporation. Specifically, for-profit websites must attempt to combine the needs of pharmaceutical companies, insurance companies, and patients. Non-profit health websites such as Centers for Disease Control or the Mayo Clinic do not include the interest of commercial entities such as pharmaceutical companies. However, the Mayo Clinic is dependent on their ability to continue to provide patient care since the website exists as an extension of the medical services they provide. The Centers for Disease Control’s continued existence is dependent on government’s rule. Even though WebMD, Mayo Clinic, and the Center for Disease Control all maintain health websites, there is no official governmental

or corporate oversight of health care websites. However, health websites do tend to have editorial boards that, to a varying degree, oversee and maintain accuracy of the information contained on the website. Currently the closest thing to regulation of health websites comes from a nongovernmental organization. The Health on the Net Foundation is a nongovernmental organization that seeks to authenticate health websites, verifying the quality of the information that is presented to consumers. The Health on the Net Foundation offers “HONcode” certification for sites that the organization has deemed to offer quality accurate health information. The HONcode for medical and health websites according to Health on the Net Foundation (2011) examines health websites on eight categories: (1) Authoritative (indicates the qualifications of the authors), (2) Complementarity (information should support, not replace, the doctor-patient relationship), (3) Privacy (respect the privacy and confidentiality of personal data submitted to the site by the visitor), (4) Attribution (cite the sources of published information, date medical and help pages), (5) Justifiability (same as back up claims relating to benefits and performance), (6) Transparency (accessible presentation, accurate e-mail contact), (7) Financial disclosure (identify funding sources), (8) Advertising policy (clearly distinguish advertising from editorial content). When a health website is marked with the HONCode, a patient knows that a group of people outside of the corporation has reviewed the information and certified that the medical information contained on the website should be accurate. In a sense this certification by the Health on the Net Foundation can be seen as similar to a doctor being granted a medical degree. While the scope of the two is vastly different, both the HONCode and a medical degree are means of conveying that a patient-consumer is about to receive information that has been reviewed and has been considered quality information. However, the HONCode is not

necessarily a constant oversight in the way a human health provider has constant oversight in the form of licensing boards for example.

The quality of information provided by health websites is increasingly important as more people use such websites to receive medical information and advice instead of or in conjunction with their health care providers. It is not surprising that patients are using the Internet to search for health information. It could be argued that people are more likely to use the Internet to search for all information because of the convenience, but it is also significant in terms of cost. The cost saving associated with searching for information on the Internet is especially true in terms of health care. Instead of making an appointment with a physician and paying for a visit, a person can quite simply conduct a quick search on the Internet. The savings in terms of time are quite obvious since it might take a few minutes to find an answer to a health question via the Internet compared to asking a health professional, which requires making an appointment, traveling to and from the appointment, and the spending time at the actual appointment. One could argue that a patient can call his or her health care provider, however, that assumes that a patient is able to call during normal business hours and that the physician is available for a phone consultation. Research has confirmed that patients are opting to go on to the Internet to access their health information. According to the Pew Research Center's Internet and American Life Project (Fox, 2011), 75 percent of American adults go online for any reason. Of those adults that are online, almost 60 percent search for health information online. Those who are most likely to go online to search for health information are women, are white, are 18 to 49 years old, have at least some college education, and live in higher income households (Fox, 2011). In addition, adults, regardless of demographics, who are unpaid caretakers to a loved one, are also most likely to go online in search of health care information. The Center also found that those who

are less than 50 percent likely to go online and search of health information include African-Americans, Latinos, those with disabilities, high school education or less, and those who live in a household with an annual income of 30,000 or less (Fox, 2011). Thus those who are less likely to go online in search of health care information are also those who are members of oppressed identity categories that usually receive lower quality of health care. However, as previously mentioned in this chapter the proliferation of smartphones is helping to reduce this divide because for those searching for health care information on smartphones specifically tend to be members of the groups that search for health care information on the Internet less often. The percentage of people who are going online to search for health information on the Internet will continue to be of great importance because of the number of people that value that information. In research conducted by West and Miller (2009), Internet users that have gone online in search of health information, over half indicated that the information they gathered affected their health care decisions and it changed how they approached their health care (West and Miller, 2009). In addition, about half indicated that this prompted them to ask questions of their health care providers. It is also important to note that when asked people who search for health care information said that their goal is to gain knowledge and make themselves feel more confident when interacting with health care professionals (West and Miller, 2009).

I would argue that having confidence when interacting with health care professionals is fundamentally important to patients being able to be proactive in their health care rather than waiting until they become ill. Furthermore, it is possible that patients having access to health information in the form of a website is a more effective means of leading to healthy behavior. One-way information transmission from the provider to the patient can potentially be ineffective. Nauhauser and Kreps (2003) found that patients are more likely to engage in proper medical

adherence if the information exchange with health care providers is interactive. Furthermore, information that is tailored to a patient's specific needs is more likely to be effective (Nauhauser and Kreps, 2003). Since patients are able to guide and control their health information gathering when they visit a health website, the health information that they receive is more likely to be effective. Patient can seek the exact information they are looking for and tailor their website visit to fit their needs. Nauhauser and Kreps (2003) note the potential success of e-health and health promotion stating:

E-health media could address some of the limitations of traditional health communication through improved customization, contextuality, interactivity and mixed media.

Theoretically, e-health communication could combine these features, unlike our current 'segmented' approaches. Overall expected benefits might include: more intense personal engagement and participation of the users; widespread dissemination; information that is customized for and accessible to diverse audiences, especially traditionally underserved groups; access to information on demand '24/7'; linkages to others for social support; and information that relates more realistically to life issues. (p. 12-13)

Part of the shift included in e-health is in the form of patient interaction and agency. The blending of health care and Web 2.0 technology has led to the emergence of the Health 2.0 movement. The Health 2.0 movement aims to do what Nauhauser and Kreps (2003) assert to be the potential for e-health, pro-active patient involvement in their health care.

Research by Marina Levina (2012a) focuses mainly on the interactions that patient-consumers have with each other and how the health information exchange between them affects traditional models of health care. While it is inevitable that there will be misinformation given between lay people, I am seeking to question the place that lies between doctors only and

patients only. I am searching to examine the social discourse area in which health “experts,” who are not necessarily health care practitioners, provide information to laypeople that form a place of health and health care “knowledge.” It is a liminal in-between space where people who are deemed knowledgeable enough to be health writers are given the opportunity to pass along information to patient-consumers who then exchange that information through the new Health 2.0 framework.

Race and Cyberspace

As George Lipsitz (2006) notes, “whiteness never has to speak its name, never has to acknowledge its role as an organizing principle in social and cultural relations” (p. 1). Several scholars have examined the whiteness of cyberspace (Everett, 2009; McPherson, 2000; Nakamura, 2002). The hope for the Internet was the creation of a cyberutopia devoid of race and ethnicity, a true post-racial society. However, that has not occurred. The term digital divide has been used to describe the differences between access and use of technology in general and the Internet specifically. Larry Irving and his colleagues in the Clinton Administration first used the term in 1995 (Banks, 2006). Although the term digital divide is most often associated with access, Adam J Banks (2006) argues for the concept of the Digital Divide as a part of a larger Black rhetorical tradition that includes verbal and visual as well as electronic discursive practices. Specifically, Black rhetorical traditions have historically been entrenched in resistance to exclusionary practices (e.g. Jim Crow) whose purposes were to keep the Black population subjugated. Banks notes that technology plays largely into this pattern. It is technologies that (re)create and (re)invent power structures that are at the core of socioeconomic and sociopolitical institutions. Along the same lines, Everett (2009) makes the argument that the debate over the digital divide has a rhetorical history of racial subordination and suppression. In fact, Everett

recounts noticing that the relationship of “master/slave” is used within the bootup language of her computer to dictate an order of operations. It is unlikely that the people that created the code for that computer’s bootup sequence intentionally had any racial connotations in using the master/slave relationship, however, the choice of that particular relationship instead of say primary/secondary does lead one to pause and wonder why the master/slave relationship was chosen.

An interesting finding regarding the digital divide suggests that Blacks have a more positive attitude towards technology than similarly socioeconomically located whites. In research conducted by Mossberger, Tolbert, & Gillbert (2006), Blacks were also more likely to have used computers in job searches and in taking online courses, however, Blacks were less likely to report having access to computers and the Internet. Echoing Banks (2006) assertions, the authors go on to argue that Blacks also tend to not have the knowledge or skill to use computers and the Internet, even when controlling for education and income (Mossberger, et al, 2006). However, when controlling for educational attainment level there is not a measure for the quality of that education. Therefore, a low income student without home access to a computer who has graduated from a low income high school that lacks adequate access to computers for their students to use will have a very different technological skill level compared to a high income student with a personal laptop who graduated from a top tier high school. Both have high school diplomas, however, the opportunities that they had to learn technology skills during their high school experiences would be vastly different. The historical exclusion from technologies leads to a problem associated with compounded knowledge. Compounded knowledge is necessary to be able to effectively access certain technologies. For example, it is much easier to navigate a website if one is familiar with the Internet in general. Navigation of a

website that is related to knowledge acquisition is a specific skill that is learned over time and multiple uses. In other words, one would not navigate through a site like WebMD in the same way that they would navigate through the social networking site such as Facebook. Thus past research has not necessarily provided a clear picture of what is actually behind the digital divide.

It is also important to note that lacking access does not necessarily mean there is not a desire to achieve access. According to Mossberger et al. (2006) when surveyed Blacks and Latinos showed enthusiasm in regards to technology. From this the authors concluded that technology divides are more closely related to poverty spaces rather than some intrinsic lack of desire ("culture of poverty") to engage with technology. Specifically, Mossberger et al. (2006) assert that the digital divide is a cumulative effect. The authors explain how the digital divide is actually embedded within social institutions rather than a merely being an absence of technology or people's lack of knowledge regarding technology. Social networks also play a large part in the digital divide (Mossberger et al., 2006). In the authors' study, subjects often stated that they would use technology at a friend or family members' house (Mossberger et al., 2006). When considering the type of information that people searching WebMD might look for, searching for information at a friend or family members' house can either be helpful or a hindrance. Being in a friend or family members' space can be helpful because it is a person's social support network. Thus the anxiety of potentially negative information might be minimized because of the presence of a person's emotional support network. On the other hand, the mere presence of others might create a space in which a person is uncomfortable seeking out medical and health information on the Internet. Therefore, even though a person needs the information they might opt to not use the Internet to seek out medical and health information.

It is important to note that divide does not mean absences. There has always been a Black presence on the Internet, from earlier adopters to current daily users. Everett (2009) highlights that as early as 1995 Yahoo! created a category specifically centered on Black content.

Ultimately Everett is optimistic about the possible uses of the Internet as a space for revolutionary practices. Furthermore, Web 2.0 has opened up a space that creates a hybridization of conversations and written communication which “suggests a parallel or affinity to various traditions of black technocultural syncretisms” (Everett, 2009, p. 13). Despite the presence of Black content and of Blacks who are well versed in the use of cyberspace, the rhetoric surrounding the digital divide is endemic of a larger discursive culture that assumes a lack of skill and knowledge of Black participants. Thus the focus is often on what is lacking rather than what is present.

The digital divide however continues deeper when we look at who is producing content on the Internet. The lack of Blacks (and women) in positions such as web designers and coders speaks to a larger rhetorical and discursive tradition in which Blacks are denied a seat at the proverbial table. Quoting Tyrone D. Taborn (p. 151) Evertte (2009) refers to the phrase “tricknologists” to describe the slight of hand that comes with praise of the closing of the digital divide when in fact it is a closing in consumerism not in production or knowledge creation. Furthermore globalization and globalized capitalist economy has made it even more difficult Black technology producers to enter into the behind the scenes creation and production related to the Internet. Evertte (2009), referencing Donna Haraway notes that there has been the development of a new working class comprised of Third World women who are used for high tech exporting of electronic and tech knowledge in ways that previously exploited labor produced material goods. The development and increase of this Third World working class has become “a sort of

high-tech slavery or techno-colonialism that injures foreign laborers and completely devastates the high-tech aspirations and employment options of undereducated and undertrained black and other minority laborers in the United States” (Evertte, 2009, p. 153). Similarly, as argued by Thomas Blair, the presence of a racial digital divide can also be attributed to the lack of black people in the IT field, specifically in the areas of web design and content editors. As such it is not illogical to conclude that this absence of people of color behind the scenes will inevitably lead to an absence of presence of people of color on websites.⁷

Racial Health Care Disparities Offline

Health care disparities refers to the fact that “persons who have equal access to health care face differences in healthcare treatment and thus poor healthcare outcomes because of discrimination or the operation of the health care and legal systems” (White-Means et al., 2009, p. 437). While the racial digital divide and racial health care disparities do not immediately seem to be related they are intertwined inequalities that are built into social institutions. The racial digital divide, as Banks (2006) argues has a cumulative effect. Parents who do not use computers and the Internet have children who are less likely to use technology. These children also tend to be students that are less likely to use the Internet for school related academic endeavors such as research, writing and submitting assignments, or completing and submitting applications for college. Lack of use in academia ultimately leads to few educational prospects, which then will affect future employment opportunities. Currently, the American system of

⁷ In this regard we can take a look at other media forms, most notably television and film. When there is an absence of people of color in key roles there also tends to be an absence of diverse representations. This is not always the case. Examples being shows such as *Girlfriends*, which was produced by actor Kelsey Grammer or *The George Lopez Show*, which was produced by Sandra Bullock. Although both show did end somewhat abruptly, they both enjoyed some success during their production.

health care is structured in a way that the most common – and the cheapest – way that people receive health insurance is through their employers⁸. Health insurance is most often associated with higher paying jobs that require additional education beyond high school. Thus receiving a quality education and continuing to a secondary education will also affect a person's health and health care.

The ways that health care disparities are experienced by patients can vary greatly in that, “discrimination may not be overt; it could be based on conscious or unconscious bias and prejudice, explicit or implicit stereotyping, or uncertainty faced by provider who has difficulty communicating with the patient whose race, cultural background, and/or socioeconomic status differs from that of the provider” (White-Means et al., 2009, p. 437). One approach the health community has adopted to address the issue of health care disparities has been for health care providers to focus on cultural competencies. As stated by Betancourt et al. (2005) “the goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture or language proficiency” (p. 499). However, research by White-Means et al. (2009) shows that it is not even race or ethnicity per se, but variations in skin tone that can account for potential mistreatment of patients by health care practitioners. The authors studied racial bias of medical students entering into the health care field by the use of an implicit association test that showed that all health care students studied (nursing, pharmacy, and medical) regardless of race, showed an implicit

⁸ As of this writing, provisions of the Affordable Care Act have been slowly rolled out. State governments have been resistant to receiving federal money to extend Medicaid and lack of information about the government run health insurance marketplace, there will be an ideological and practical lag to move away from the notion that health care should be provided through a person's job.

preference for whites and lighter skin (White et al., 2009).⁹ Thus in all areas of care there appears to be a tendency of health care providers to be bias towards non-whites and darker skin patients before the patients walk through the door. When the authors examined the results based on the race of study participants they found that Black and Hispanic students scored significantly higher on cultural competency. Interestingly, biracial nursing students scored the highest, yet biracial medical students scored lower than White medical students. This is an important finding when considering that the people who determine course of treatment are the medical students who scored low on cultural competency, and not the nurses who scored high on cultural competency.

Two often cited studies regarding health care disparities (Schulman et al., 1999; van Ryn & Burke, 2000) give early indicators of physicians' complacency in racial health care disparities. Schulman et al. (1999) found that physicians would refer patients with the same symptoms at different rates based on gender and race. Specifically, Black women were least likely to be recommended for cardiac care than for other patients. Van Ryn and Burke (2000) found similar results to that of Schulman et al, specifically, that the race of the patient "is associated with physicians' assessment of patient intelligence, feelings of affiliation toward the patient, and beliefs about patients' likelihood of high-risk behaviors (substance abuse) and noncompliance." (van Ryn and Burke, 2000, p. 822). The biases that health care professionals may carry appears to be a function of their preconceived biases but also a function of learned biases. White-Means

⁹ Implicit association tests (IATs) have been used in social psychology as a way of measuring subjects' association of two targets (usually social characteristics such as black/white or male/female) with an attribute (pleasant versus unpleasant). IATs are designed to measure a person's underlying subconscious evaluations and associations and are particularly useful in examining racial bias and attitudes because IATs "resist self-presentational forces that can mask personally or socially undesirable evaluative associations, such as the ethnic and racial attitudes" (Greenwald, McGhee, and Schwartz, 1998, p.1478)

et al. (2009) note previous research that found medical students were less committed to helping underserved patient populations by the time they reached their fourth year of medical school compared to when they first entered. These findings suggest that students are learning to become less compassionate and committed to serving traditionally underserved populations, including racial minorities, rather than more compassionate and committed, despite the push of organizations and medical schools to integrate cultural competency in their training. White-Means et al. (2009) found that when surveying entering and matriculating nursing, pharmacy, and medical students they did tend to score higher than previous research suggests on cultural competency measures. Unfortunately, the same students consistently scored low on being able to articulate what is meant by cultural competency. Furthermore, this finding coupled with the finding that students become less compassionate and committed to helping underserved populations, begs the question: has progress really been made if students do not understand the concept of cultural competency?

Another area of concern when examining health care disparities is to consider the unmet medical needs of patients. Unmet medical needs – an indicator of patient access to care- is often measured by self-reporting of the patient (Wiltshire et al., 2009). Wiltshire et al. (2009) found that when studying unmet medical needs of female patients, Black women were more likely to lack adequate (or any) health insurance, be in poor health, and be of a low socioeconomic status thus making it harder to obtain treatment and care. Furthermore, the researchers found that an important measure of perceived unmet medical need to be related to educational attainment. Specifically, the lower patients educational attainment the higher their unmet medical needs (Wiltshire et al., 2009). Kennedy et al. (2007) examined the relationship between educational attainment and income combined and had similar results. The authors research shows that

combining income level and educational attainment gives a more precise measure of a person's socioeconomic level, since income level and educational level are correlated but do not have an absolute relationship. However, the authors also show, like Wiltshire et al., (2009), that lower socioeconomic levels are correlated with racial health care disparities (Kennedy et al., 2007). Furthermore, it is not just the socioeconomic status of a patient that influences racial health care disparities. Cook and Manning (2009) found that even when health care expenditures are consistent between patients there are still racial health care disparities.

As health care moves away from being just in doctors offices and hospitals and into cyberspace, examining whether or not those offline racial health care disparities exist online as well becomes increasingly important. Miller and West (2009) articulate the intertwined relationship of health care disparities and technology by stating that:

There are well-documented gaps in healthcare in the United States and many of the disparities have carried over into the world of digital medicine. Individuals who have low incomes, who are poorly educated, and you live in rural areas have less access to quality medical care than those who have higher incomes and education and live in metropolitan communities [...] Rather than overcoming inequality, technology reinforces existing systematic inequalities based on age, gender, race, income, education, and geographic location (p. 10-11)

Furthermore the information that is contained on health websites is written using language and technical jargon that is above the education level of many of the people who are on the losing end of health care disparities. Understanding and compliance of medical treatment is directly related to the patient's level of health literacy (Miller and West, 2009). Thus, similar to the findings of Banks (2006) regarding the digital divide as it relates to rhetorical practices, health

care disparities are larger than merely lacking equal access to health care. Racial health care disparities are part of a larger systemic network of inequalities that include historical exclusion from other social institutions such as education.

“We never look at just one thing; we are always looking at the relation between things and ourselves.” –John Berger, Ways of Seeing

CHAPTER 3: METHODOLOGY

Researching the discourse of health care must contain an examination of what constitutes illness and how that differs from wellness and health. Who makes the decisions as to what is considered to be normal for the human body? What signifies sickness? Foucault pushes us to consider the body as an object that “defines, by natural right, the space of origin and of distribution of disease” (1963/1994, p. 3). As such the body is understood to be something that can be analyzed in terms of a Cartesian analysis. Thus the examination of disease and not merely the examination of the body becomes a practice in a form of map reading where the body is a landscape that is covered in either markers of sickness or wellness. Foucault’s idea of sickness and disease seems to heavily rely on the corporeal nature of medicine. However, the Internet and cyberspace has changed the reliance on a corporeal being to examine and instead has become more ethereal and difficult to identify.

If the Internet has become the preferred method to communicate and learning as Lawson Mack (2001) suggests, it is increasingly important to examine this space in which these everyday interactions are taking place.

Examining Cyberspace

The fluid and often times ambiguous nature of cyberspace leads to some specific challenges when conducting a research study such as the one presented in this work. In thinking about examining cyberspace it becomes important to think about what is this thing that we call “cyberspace.” As noted in Chapter 2, the terms Internet and cyberspace are used interchangeably however, I would argue that for the purposes of this study it is important to distinguish between

the hardware that allows for communication between inhuman machines through on-off, 1s and 0s and the ephemeral ambiguous geographic space that is created through people interacting through web traffic. The term cyberspace is largely credited to William Gibson's 1984 novel *Neuromancer*:

Cyberspace. A consensual hallucination experienced daily by billions of legitimate operators, in every nation, by children being taught mathematical concepts...A graphical representation of data abstracted from the banks of every computer in the human system. Unthinkable complexity. Lines of light ranged in the nonspace of the mind, clusters and constellations of data. Like city lights, receding.

When thinking of cyberspace in terms of a collective consciousness of an innumerable a/synchronous mass of people controlling content and information dissemination, it becomes clear that the study of cyberspace can become difficult and overwhelming if it is not approached systematically.

Cyberspace is constantly changing yet it is still important to be able to maintain some systemic approach to analyzing it. One of the main complications with the examination of cyberspace lies in the constantly changing nature of the Internet. Cyberspace as a site of study can be considered a "difficult, moving target of analysis" (Everette, 2009, p. 10). Everett uses the term "hyper-ephemerality of the cybertext" to describe the challenge of doing content analysis on cyberspace because of the constant change and movement of the subject of study. The difficulty of studying cyberspace is due in part to the mixture of multiple mediums including text, graphics, audio, and video. The multiplicity of cyberspace makes it possible to break from linearity that is required of traditional text such as books. Breaking the fixed trajectory of text is good for creating a complexity of meaning and an enriched user experience. Hyperlinks also

allow the reader to act as the author to a certain degree by allowing the reader control over consumed content in a way that was not previously possible. Furthermore, the possibility of authors traveling through information by their choice leads to the disruption of temporality. Time and space are simultaneously compressed and elongated, rendering both ambiguous (Weare and Lin, 2010).

The Internet began as mainly a textual medium, but over time grew into a primarily visual one. In describing images John Berger (1990) could easily have been describing the nature of websites when he states that “[an] image is a sight which has been recreated or reproduced. It is an appearance, or a set of appearances, which has been detached from the place and time in which it first made its appearance and preserved – for a few moments or a few centuries.” (Berger, 1990, p. 9-10). Berger is speaking about images in terms of visual culture analysis, which is an important component of analyzing websites. However, it is difficult to use one method of analysis in a traditional manner for a study of cyberspace. To account for the constantly changing nature of cyberspace, in this study, WebMD will be examined in terms of snap shots in time so to speak. It stands to reason that viewing the website at various random intervals will give a good impression of what the website as a whole is like and that it will be similar to the surfing and Internet consumer habits of the average user. By using screen captures of the websites pages, the goal is to create a stationary product on which a more complete analysis can be performed.

The thing that potentially offers the most promise from visual culture studies is the idea that the way we see things is a result of what we have experienced, our knowledge and ideologies. The use of visual culture studies to examine the Internet in general and WebMD specifically holds promise as a methodology because like images in art and motion pictures,

websites provide digital imagery that is no less “real” than previous pictorial forms. As Nakamura (2002) states, “digital objects, [. . .] do possess distinctive cultures of bodily representation, flow, privacy, identity, and circulation and have created unique communicative and institutional contexts” (p. 13). While the difference of the representations on a site such as WebMD from its predecessors of art are somewhat clear – digital and photographic representations versus drawn or painted representations – similar conventions of a producer are present. The designers and editors of WebMD are the ones that act as the producers of the images¹⁰ that are present on WebMD. Thus the content creators of WebMD, who are presumably guided by the desires of the corporation, create images that are of their making in a way that artists create drawings and painting which represent their way of seeing. In cyberspace the consumer acts not only as the passive participant, but also as an active creator in that they are able to travel through the website based on their own wishes and commit their desired amount of time in each subsequent space. However, while the consumer has choice in the creation of space, it is limited choice. The content editors (and ultimately the corporation) are the ones that make a decision as to what is available for consumption by the consumer.

In addition to the visual aspects of websites, one must also consider the accompanying text. John Berger (1990) argues that when words are placed in proximity to an image, the words change the image. The image ceases to be just an image for interpretation, but becomes an illustration for the sentence (Berger, 1990). In its most basic form, content analysis is a method of studying communicated messages and their environments. The attempt of content analysis is to utilize a systematic analysis to maintain a sense of objectivity. This creates a special problem

¹⁰ Even when the images on the website are not produced by the creators of WebMD, they are chosen from stock images. Thus, in some ways editors are involved in image production, in that they are responsible for selecting and arranging images.

when examining the content of the Internet because it is constantly in a state of flux as it changes. In addition, it is not always clear who is creating the content or if the creators of the content have any control over what information, images, and text is presented on the website.

Who's Controlling Content?

Winner (1986) suggests that there are two different ways that people can think about technology. On one hand, technology is useful for community; while on the other technology becomes inherently political. Technologies that are inherently political are also technologies that ultimately benefit from constructions of power either directly or through social institutions. The power relationships are then created through the politicalness of the created technology and then maintained by the continuation of structural systemic support of the technology. When thinking about the political nature of technology it is important to note that technology is not always related to complex electronic devices. An example of this would be the creation of physical structures which seek to control crowd movements and population flow. Construction of barriers in and of themselves may not seem to be political but rather merely a constructive means of arrangements of physical space. However, the ways in which physical barriers are constructed are inherently political by their ability to limit and control people's movements. In limiting people's movement, you are also limiting people's ability to freely choose where they go, how they engage with their world and with others. For the purposes of this research, I am interested in considering the ways that the Internet in general creates a political space and how that space is controlled and by whom. Furthermore, I am seeking to examine how the controlling of space and information flow shapes discourses about race and health care in cyberspace.

The effect of the Internet on information creation and exchange can be seen from the way that journalism has been affected. As John V. Pavlik notes (qtd in Weare and Lin, 2002):

There is emerging a new form of journalism whose distinguishing qualities include ubiquitous news, global information access, instantaneous reporting, interactivity, multimedia content and extreme content customization. . . New media are bring about realignment of the relationships between and among news organizations, journalists, and their many publics, including audiences, sources, competitors, advertisers and governments. (p. 275)

A similar shift has occurred when looking at the effect of the Internet on health information exchange. The interactive nature of cyberspace makes it seem that users have more power than they actually do. The existence of health care as a social institution offline establishes a pattern of power and authority that can then be transposed into cyberspace. Winner goes on to argue that power and authority are organized through the social patterns that are present around technical environments (Winner, 1986). This occurs in one of two ways: either the design of a technological system creates a way of establishing power and authority within a given setting or certain properties inherent in the technological system are linked to already established power and authority in social institutions (Winner, 1986). I would argue that within WebMD we see both at play. Power and authority is automatically present because it is a website. A certain level of knowledge and therefore power is assumed with knowing the appropriate technology. As noted by Nakamura (2002) “the Internet has spawned a whole new set of vocabulary and specialized terminology because it is a new tool for communicating that has enabled a genuinely new discursive field, a way of generating and consuming language and signs that is distinctively different from other, older media” (p. 1). Furthermore, even though the user has control, to a certain degree, because they are able to navigate through the various areas of the website in an

order of their choosing, they are still limited to what is given to them by the content creators and web editors. Thus the creators and editors of the website maintain power and authority over the information that is presented. In addition, the institution of medicine has had centuries of power and authority established before the Internet came into being. As such based purely on the subject matter, WebMD offers a continuation of the power and authority structure that is present in the social institution that is medicine in its new form of technology.

I would argue that the same types of changes could also be seen in the way health information is transmitted. Technology can be viewed as being a tool of authoritarian rule or a means of democratic equalization. As noted in Chapter 2, the Health 2.0 movement merges Web 2.0 technologies and e-health technologies. The goal of the Health 2.0 movement is to move health care from the authoritarian rule of the medical establishment into the democratizing hands of patients, allowing them to become proactive members of their health care. However, as Marina Levina (2012a) notes, although there is hope of Health 2.0 placing power in the hands of the consumer and thus removing the institutional power of health care system, “this does not mean that network power is democratic, but rather that it is a diffuse system of control and regulation operating through a multitude of nodes” (p. 148).

When considering cyberspace, the fluidity of location does not negate the social and economic control of a website. Any examination of a for-profit company’s website would also require an examination of the companies financial ties and interests. WebMD.com is owned by an American company¹¹, WebMD Health Corp. In addition to WebMD.com, WebMD Health

¹¹ As of this writing WebMD Health Corp is currently only has an American version of WebMD.com. However, the company has had meetings with Rupert Murdoch’s company News Corp in the past to negotiate a deal that would make WebMD a global enterprise. The deals between News Corp and WebMD have been renegotiated several times over the years, but currently News Corp no longer has plans to make duplicate international versions of WebMD.com.

Corp owns the consumer sites MedicineNet.com, eMedicineHealth.com, RxList.com and the professional sites Medscape.com and theheart.org. In addition to information websites, WebMD Health Corp also owns health portals for health insurance plans that contain information about a patients' medical claims, doctor location tools, health risk assessments, and health coaching. WebMD Health Corp also provides publishing services, which covers academic publishing as well as WebMD the Magazine which initially was published only for medical offices but has since expanded to be available to consumers in print, online and iPad versions. The vast variety of holdings of WebMD Health Corp are indicators that the importance of the company is that of any other corporation, health related or not, which is to make the largest profit possible. A key to expanding profit is to diversify corporations' holdings so they can earn money in multiple consumer markets with a variety of customers.

If we make the assumption that certain technologies required their environments to be structured in a specific way to function, it could be argued that WebMD.com necessitates user input. However once the user navigates through the site and becomes a subauthor of sorts, they also relinquishing control and their data even though Health 2.0 has created a belief the possibilities of a health utopia just as long as users engage with Web 2.0 technologies in their health care (Levina, 2012a). The user thus provides labor for free to the website who then profits on the users labor. In terms of health care, it could be argued that users would only be willingly to do this in environments such as the Internet. If a doctor asked a patient to draw their own blood, run their own labs, and make diagnoses the practice of medicine would not exist for long. Patients would lack confidence in the doctor's knowledge base and ultimately in the doctor's necessity, if they, the patient, is performing the majority of tasks. However, in a sense that is what is being expected of consumers using health websites such as WebMD. Consumers are

given the task of assessing their symptoms and self-diagnosing. This is considered normal and reasonable in the context of cyberspace. As Winner (1986) notes “some kinds of technology require their social environments to be structured in a particular way in much the same sense that an automobile requires wheels in order to move. The thing could not exist as an effective operating entity unless certain social as well as material conditions were met” (p. 32). In a sense when the user also becomes the producer there is an element of labor in the knowledge creation that is occurring. In fact it can be seen in Marxian terms, that the consumers/patient/user/author is “actively involved in the daily creation and recreation, production and reproduction of the world in which they live” (Winner, 1986, p. 15). Thus, there is created a certain type of false class consciousness in which the consumer is also the worker, who through their use of WebMD, is also disguising the political and economic control and inequalities taking place on the site.

Rise of the Medical Gaze

Foucault argues that medicine, as a profession, is truly born out of the concept of the medical gaze, the medical gaze is a way of seeing a patient. Physicians and other medical professionals are trained in seeing sickness. The training of medical professionals is clearly one of power in which knowledge is passed from one person to the next. Thus what is determined to be sickness is called such because of who is in power to declare it so. In the preface to *The Birth of a Clinic*, Foucault (1963/1994) rightly notes that there is a need to not only consider what is spoken and visible in language but also to consider that which is absent and unsaid in the hollow space between to truly understand discourse. It is also understandable that in cyberspace there is

a relationship between that which is clicked upon and that which is understood to be reality.¹² Seeing in the 18th century was a form of knowledge creation that required the formation of information based on what was unseen, but it was little more than naming those things that were mythic and unseen (Foucault, 1963/1994). In the process of naming these things are brought into a solidity that makes them “real” and part of truth and knowledge as it relates to medicine. In terms of health, this would suggest that articulating means of health care as well as speaking of those who should receive health care would make understanding clear.

I propose that Foucault’s work is most beneficial in his concept of the medical gaze. It is important to note that in using the medical gaze and in seeing sickness, what is unseen is also of great important. That is to say, the absences of sickness helps to define what is in fact disease. Foucault argues that “the human body defines, by natural right, the space of origin and of distribution of disease” (Foucault, 1963/1994, p. 2) but that becomes complicated in the age of cyberspace. With websites such as WebMD, which visualize disease not on the actual body but on replications of the body and imagery of the body, determining what is disease and subsequently health becomes more complicated. It also raises the question of who is the one performing the medical gaze? I would argue that the medical consultants, health writers, content editors, and the consumer-patients are all performing the medical gaze, often at the same time.

For Foucault, space becomes central to the concept of disease. “Disease” only becomes such based on its distance from “well.” Differences in diseases only are different in terms of their closeness to other diseases. Cyberspace intrinsically compresses space, causing the meaning of space to be ambiguous. In addition to the complication of the meaning of space,

¹² In this instance “reality” is referring to offline environments. However it must be restated that offline *and* online environments and interaction are both reality.

cyberspace challenges offline notions of time. Time is of the essence to Foucault in the formation of knowledge related to disease. Specifically, it is the progression of the disease that makes it possible to identify that it is in fact a disease and to specify what the disease is. It is the physician's ability to watch the progression of the disease, to be able to recognize the relationship of space and time as it relates to disease in the patient's body that bestows upon the physician the title of learned individual. Howell, referencing Benjamin Rush, a physician in the 18th century, states "knowing science was simply not an essential tool for an excellent physician" (Howell, 2004, p. 333). This statement by Rush alludes to Foucault's description of the formation of medical knowledge through learning the medical gaze. The science of disease, such as how pathogens are transmitted, is not as important as being able to look upon a body and determine that the body is ill. However, in the modern era medicine is believed to be firmly rooted in scientific inquiry, which begs the question, how did this shift occur? Foucault argues that medicine became a science as it was being defined and in terms of its possibility and it is this solidity of medical knowledge that makes it now possible to critically examine old understanding of medicine and disease in the presence of "a new experience of disease coming into being" (Foucault, 1963/1994). However, there is not a complete departure from health care providers use of the medical gaze being a fundamental part of the diagnostic procedure.

Deborah Lupton (2012) states that by the 1950s, "while disease was still seen to exist within the human body, discovered through interrogation of the patient, there was a second strand to medical perception that viewed illness as existing in the social spaces between bodies. Clinical method now required techniques to map and monitor this space, demanding that the patient's view be heard" (p. 85). The inclusion of the patient's voice into the diagnostic procedure could be thought of as an early precursor to patient involvement that is seen later in exchanges between

doctors in patients that encourage patient involvement. Cyberspace, and specifically health in cyberspace, has created yet another moment of change in medical information and knowledge transmission that provides an opportunity to critically examine medicine and disease. Of specific importance to this research project, it provides an opportunity to examine the ways that health care disparities that are present in offline environments are exhibited online. In addition, it provides a means of helping to explain how these existing disparities function.

Which Bodies Matter?

Butler (1993) asserts that “the materiality of bodies is [not] simply and only a linguistic effect which is reducible to a set of signifiers” (p. 30). Thus, bodies cannot be defined in strict and static terms. Furthermore, the materiality of the body is complicated by the performative aspects of the body and the performative aspects of the signifiers that mark the body. Although Butler’s work is focused on sex and gender, the concepts of her theoretical work can also be applied to bodies in terms of race since race, much like gender, is a construction based on floating, fluid biological determinants. In this regard, bodies that matter can be thought of, for the purposes of this research, to be bodies that are deemed to follow expected performative aspects of the materiality of the body. That is to say that racialized bodies become racialized because of the performance of race within the context of social expectations and power systems. Omi and Winant (1994) similarly speak of signifiers of the body. They define race as “a concept which signifies and symbolizes social conflicts and interests by referring to different types of human bodies” (Omi and Winant, 1994, p. 55). Thus the racialized body becomes a site that marks sociohistorical meanings of power and (re)creation of social institutions. Using the work of Cathy Cohen, Judith Halberstam (2005) notes how some bodies are considered expendable in both mainstream and marginal communities. Cohen was speaking specifically about black

queers or poor drug users and the relationship to the AIDS epidemic. However, the same can be stated more generally across various realms of racialized existence. The White body, specifically White male body, is elevated to the level of generality, which in turn is subjugated to anything outside of that body into a specific individual experience (Halberstam, 2005).

Are Patients Becoming Doctors?

In the case of WebMD and other such health websites, how patients (consumers) receive medical information has changed. The patient has the potential to become the authority in regards to their personal health care, and in certain instances is encouraged to do so.¹³ Instead of medical information being received as a one-way communication from the physician to the patient, the patient is able to act as their own “second opinion” by going to a health website to search for information about a diagnosis. Patients are no longer going to their doctors and in doing so patients are stripping doctors first of their ability to be the sole performers of the medical gaze. Not only are patients enacting the medical gaze, the use of the medical gaze as it is related to gathering information via the Internet has increasingly become second nature, and even common place for the sick body.

Howell argues that one of the most important aspects of the Internet is that unlike previous technologies, the user is also the producer. He also rightly notes the paradox that this creates in terms of information transmission (Howell, 2004):

¹³ In lay conversation, media oversight and such as it is suggested that patients “research” symptoms and/or a disease. While the caveat of “see your doctor” is often added to the end, the meaning has become understood to mean, go to the Internet and search health websites for information. Research in this case does not mean to go to medical journals or to access case studies or research studies, it means to perform a Google search.

“‘Self-publishing’ is easy. Anyone can put up a Web site; anyone call [sic] tell his or her story to thousands (or hundreds of thousands, or millions) of people. The stories that result may be very personal and very compelling but also run the risk of being very misleading, in the general genre of ‘I was saved from cancer by [fill in the blank].’ Misleading information abounds; accurate information abounds. Attempts to systematize or standardize medical information on the Internet are under way, but such efforts run counter to the very *raison d’être* of its original creation” (p. 346)

Cyberspace creates a space in which the user is able to transverse terrain as both the consumer and the producer. Weare and Lin (2000) echo this sentiment by arguing that over time users begin to control the content that they are navigating through. Thus the content is no longer a singular author but is comprised of a decentered collective of contributors who create the structure of information exchange. When a user visits a website, such as WebMD, they are consuming content that has been created by an author other than themselves. As Berger argues, the way in which images follow each other “constructs an argument which becomes irreversible” (Berger, 1990, p. 26). However, because a user can choose where to travel, which links to which subpages, or even outside sites will be visited, the user is the consumer and also the author. In this regard there is a departure from traditional forms of visual culture such as film, however, it still creates a form of a narrative that becomes “truth.” Thus a website such as WebMD cannot be examined in terms of an easily identifiable producer and the easily identifiable consumer. The consumers of WebMD are partially producers as well. For example, as consumers click through various pages they are creating a specific object/series of objects to be consumed in a

specific sequence of their choosing, unlike a film in which a director makes those decisions for the consumer.

In a sense, the user, the website, the content creators, and editors are all acting together simultaneously to become the health care provider. However, it also creates a symbiotic relationship with the user in which the user and the website ebb and flow in dual decision-making process. Thus the question becomes, who is on the other end controlling the information that patients are receiving? In other words who becomes the new gatekeeper of medical information and knowledge, a position that was once held by health care professional? Previously it was the responsibility of the doctor to have the training and knowledge of how to gaze at a patient to read the disease upon the body, as described by Foucault. But a shift has occurred in which it is now partially the work of the consumer, to become self-taught through the information that is presented and through their chosen path through a health website to develop a medical gaze and with it gain the appropriate knowledge of the diseased body. Thus the consumer-patient has become, purposefully or not, an intermediary of medical information and knowledge. Howell (2004) argues that since patients can now find medical information before an encounter with their doctors, patient autonomy increases and the hierarchy between patient and doctor breaks down. While I agree that the patient gains autonomy in when they learn to use the medical gaze; I would argue, however, that there is also a reinforcement of the doctor as the final authority. Thus the patient becomes a type of assistant to the doctor: the patient can self diagnosis for minor ailments and can administer their own care, however, for more complex medical problems, those beyond the medical gaze of the consumer-patient, a doctor is still necessary to use their advanced level medical gaze to identify disease in the body.

Racial Health Disparities Online?

The use of visual culture studies to examine the Internet in general and WebMD specifically holds promise as a methodology because like images in art and motion pictures, websites provide digital imagery that is no less “real” than previous pictorial forms. As Nakamura (2002) states, “digital objects, [. . .] do possess distinctive cultures of bodily representation, flow, privacy, identity, and circulation and have created unique communicative and institutional contexts.” (p. 13)

I have chosen to use the homepage of WebMD and a selection of disease pages for analysis. WebMD’s website as a whole is quite massive and it would not be possible to analyze every page contained on the website effectively. As previously stated, a common measure of health care disparities is the rate and quality of screening and management of diseases. Health disparities research uses the following standard measures: infant mortality, incidence of cardiovascular disease and stroke, diabetes and HIV/AIDS. For the purposes of this research, I will be focusing on the diabetes and HIV/AIDS subsections. HIV/AIDS was chosen as a subsection because of the high level of racial health and health care disparities associated with this disease. In fact a review of the US Department of Health and Human services top disparities for African American populations reveals that the top 5 disparities are STIs (Keppel, 2007). Gonorrhea and syphilis rank above HIV/AIDS, however, HIV/AIDS was chosen as a topic of study since it is a disease that can only be managed, not cured. Another reason why I chose to focus on HIV/AIDS is because it is a disease whose incidence rate is directly related to virus transmission. Thus it is not a biological disease per se such as long term diseases like cancer or heart disease. In addition during the early history of HIV/AIDS in the United States, there was great distrust among African Americans about the origins of the disease. James H. Jones (1993)

chronicles this distrust of the government and health care professionals and links that mistrust to the events surrounding the Tuskegee Experiment. Jones (1993) rightly notes that the attitudes about HIV/AIDS among African Americans are not a manifestation of pure facts or lack thereof. Rather, it is a combination of historical sociopolitical and economic oppression.

Similarly diabetes has been chosen to examine because of its pervasive disparities among African American populations. In addition to a diagnosis rate that is almost twice that of Non-Hispanic whites (7% vs 12%), African Americans are less likely to receive quality health care in a timely manner (Black, 2002). In addition to a higher incidence rate of diabetes among African Americans, this population also experiences greater disease severity, more complications, and higher mortality rates. However, unlike HIV/AIDS when controlling for socioeconomic status researchers have found that there is not a significant difference between incident rate of diabetes between racial groups (Black, 2002). Yet research often focuses on genetic or medical mechanisms to explain the health and health care disparities associated with diabetes. Thus focusing on diabetes creates an interesting framework by which to study a type of misdirection of examination of how to combat diabetes in African American populations.

In focusing on the subsections for HIV/AIDS and for diabetes, my goal is to provide a glimpse into the ways in which WebMD has created a space – much like a teaching hospital – in which user can train themselves in an amateur form of the medical gaze upon the bodies that are present on the website. On the chosen pages of WebMD, I will use textual analysis to determine the frequency of the appearance of black bodies. The frequency of language associated with race will be determined, including overt and covert references. The same pages will be analyzed using visual culture analysis. The images as well as the page layout will be considered as part of the visual field that is being studied. In addition, authorship of the pages and the means of

accessing the subpages will be considered as part of determining the malleable authorship of the website. To examine the space of WebMD.com, first a preliminary examination was conducted that established a base of understanding of norms of WebMD. That is to say, common themes, design elements and techniques were all examined. In addition, the editorial and content staff for the website were outlined to get a clearer picture of who is creating and checking content on the site.

I made the decision to examine the WebMD at random intervals in much the same way a consumer of the site would visit the website. In doing so, I was able to explore the site at different times of day as well as on different days. In doing this, the research takes on a particular autoethnographic appeal, in that my personal choices of when to examine the site and which links to follow are largely guided by my positionality. The importance of user positionality should not be underestimated. My position on the as someone who has researched health care and healthcare disparities extensively will ultimately lead to my navigation through WebMD in a way that is inherently going to be different than that of a layperson. However I must also include within my positionality the reality of the fact that I have used WebMD when I have been ill or had undiagnosed symptoms. Thus I occupy a liminal space in which I am both researcher and consumer as I go through my examination of the website. Furthermore of the disease subsites which I'm examining are diseases which I do not have. Because of this, the links that I choose to follow may not be the same links that someone with said diseases or who is a caretaker of a person with HIV/AIDS or diabetes would choose to examine. However, this does not necessarily mean that as I journey and navigate through the website and the subsites that I would not be doing so in a way that a consumer would.

It is also important to note that I was born and raised in a city that was known to have quality medicine and health care including major university teaching hospitals as well as extensive social programs to aid in the health of its citizens. Because of this I come from a framework in which health care is abundant and of good quality. I have come to create a mental framework in which healthcare is a service that should provide many choices. This is quite different from a person who resides in an area that lacks sufficient resources regarding healthcare. I believe that this affects my belief that healthcare information should be plentiful and easily accessible to anyone regardless of race, class, or gender. This ultimately will inform my expectations of the amount of information that should be present.

I also decided to look at other web sites that are related to health. In doing so one complication has been the fact that, as previously stated, WebMD.com's parent company, WebMD Corp, owns several additional health websites. My initial goal was to compare for-profit health websites that have different parent companies. However this proved to be nearly impossible during my preliminary research. I discover that WebMD Corp, in fact, owns the majority of commercial health websites. Therefore, I opted to compare WebMD to a governmental health website and a non-profit website. I excluded websites that are geared exclusively towards healthcare professionals such as National Institutes for Health (NIH) and opted to use the Center for Disease Control's (CDC) website as the government run health website comparison and the Mayo Clinic's website as an example of a non-profit organization's health website. In using the CDC's website and the Mayo Clinic's website as a point of comparison for WebMD, I was able to compare how government, nonprofit, and for-profit organizations approach healthcare information on the Internet. The focus on WebMD is related to the intrinsic power of a for-profit company. It is important to consider the power relationship

of the governmental websites such as the CDC's, the importance of for-profit company but in a capitalistic society cannot be underemphasized.

CHAPTER 4: DATA ANALYSIS

According to WebMD's corporate website (WebMD Corp) the company's reach is vast in the field of healthcare (<http://www.wbmd.com/mission.shtml>):

WebMD is the leading provider of health information services, serving consumers, physicians, other healthcare professionals, employers and health plans. The online healthcare information, decision-support applications and communications services that we provide:

- Help consumers take an active role in managing their health by providing objective healthcare information and lifestyle information.
- Make it easier for physicians and healthcare professionals to access clinical reference sources, stay abreast of the latest clinical information, learn about new treatment options, earn continuing medical education credits and communicate with peers.
- Enable employers and health plans to provide their employees and plan members with access to personalized health and benefit information and decision support technology that helps them make informed benefit, provider and treatment choices.

However, undergirding WebMD's mission statement is the goal of corporations of any type: profit. The main focus of WebMD is profit with providing health information as the mechanism by which they are able to maximize their profit. The place of WebMD as a corporation becomes even more important in the gatekeeping method of information creation and distribution because the corporation has holdings in multiple medical fields including appointment making software,

laboratory technologies, and academic publishing, for example. In addition, other sites such as msnbc.com, yahoo.com, and medline.com all receive their medical information from WebMD. Thus WebMD is able to control more than just the information that is disseminated through its website. Initial examinations of WebMD indicate that the website's goal is not necessarily strictly about education but rather it is interested in the entertainment of site visitors. Looking at WebMD in comparison to government and non-profit health sites it becomes clear that the main goal of WebMD is to be a commerce site and not necessarily a site that provides the most comprehensive up-to-date information about health care and medicine. As a consumer site WebMD contains a great deal of advertisements and various product tie-ins. While I would argue that WebMD shares common practices of using advertisements on its website to generate funds, I would also argue that it is important to consider the ways in which WebMD functions itself as an advertisement. WebMD utilizes practices of advertisements such as gearing its content towards consumption holidays such as St. Patrick's Day.

Parts of the WebMD homepage (Figure 1) layout change daily, however, there are parts that remain relatively constant. The top of the homepage of WebMD contains a banner that is a rotating prescription drug advertisement. Medications range from allergy treatment, anti-depressants, and osteoarthritis medication. The advertisement in the header is mimicked on the right side of the page. Interestingly, it is also on the right side of the page that WebMD advertises their products as well, such as the WebMD magazine. WebMD's site also contains various apps such as a symptom check, BMI calculator, calorie calculators, and fitness and food planners. In this regard, WebMD is creating a way to draw in users and become creators and personalize their experience.



Figure 1: WebMD Homepage April 10, 2011

Marina Levine (2012b) describes users inputting data as part of their health website usage as a type of labor. The author uses the term “quantified self” (p. 14) to describe the affect labor that users participate in as part of their website experience. Levine (2012b) goes on to say that users inputting data is necessary for the collective network to exist. In the case of WebMD we can see the early stages of the need for the users data that are similar to what is observed in the Health 2.0 movement. Unlike Health 2.0, a user can still effectively use WebMD without directly inputting data.¹⁴ At its core WebMD provides health information through articles, lists, and

¹⁴ It should be noted that while a user might not be directly inputting data as would be necessary to use the BMI calculator, for example, users are still giving data to the website. The use of cookies and other tracking programs are a way that the user is giving their data to the website whether they are aware of it or not.

slideshows. Thus a user can still gain medical information and knowledge without using any of the features that require the inputting of personal data.

Overall, WebMD is packed with information on all parts of their site. There is very little free space. The user's eye jumps from one area to the next quickly and inefficiently. It becomes difficult to consume any information deeply in this scene of confusion. But WebMD does present an example of Health 2.0 and purely corporate website blending to create a space where users are consumers and producers of health care knowledge. To truly understand the nuisances of WebMD's structure and meanings it needs to be compared to other health sites not owned by WebMD Corp. For the purposes of this research I chose to compare WebMD to the website for the Mayo Clinic and the website for the Centers for Disease Control and Prevention.

The Mayo Clinic website creates an interesting comparison to WebMD. Unlike WebMD's corporate purpose of generating a profit, the Mayo Clinic states that their mission is "To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research." ("Mayo Clinic Mission and Values" n.d., para. 1). In other words, the Mayo Clinic website is secondary to the research and health care that they provide. The website is there to showcase the Mayo Clinic's offline services rather than its online content being the main focus of the organization. This is not to say that the Mayo Clinic does not attempt to also generate a profit from its website. The Mayo Clinic's website offers patients with the option to purchase books on topic such as diet, arthritis and better vision. In addition to the sell of books, consumers can also purchase wellness videos that offer information and solutions to diseases and disorders such as insomnia, high blood pressure, and fibromyalgia. The Mayo Clinic offers health care professionals self-guided

continuing education courses whereas WebMD Corp has separate sites geared specifically for health care professionals.

The Mayo Clinic's homepage is much simpler than WebMD's, with no advertising outside of its own services. Additionally, the only images that are present on the homepage is one large central image that rotates daily. Interestingly if the page is re-loaded a different image appears. Thus visitors to the Mayo Clinic's website will potentially be treated to completely different images even if they are accessing the website at the same time (Figure 2). The images are of a variety of people: children, teenagers, adults, young, old, families, couples, and single people from several different racial categories. The images also take place in a variety of settings, but seem to follow the trend of the suggestion of a person engaging in activity.



Figure 2: Mayo Clinic Homepage March 21, 2011

The Mayo Clinic's website lacks the potential for user input that WebMD does, hence it does not link up as closely with the goals of the Health 2.0 movement. However, because the users are able to make choices based on what information they are consuming there is some semblance of user inputting data. Another main difference between the Mayo Clinic's website and WebMD's is that there is a clear break down in the sections for patients, researcher, and health professionals. WebMD Corp separates information for researcher and health care professionals into completely different websites; WebMD.com is strictly a consumer based website. By

hosting information for consumers, researchers, and health care professionals on one site, the Mayo Clinic implies that their concern and focus is on providing information. It lets the user determine their level of knowledge, unlike WebMD, which lets the users think they have a certain level of knowledge when in fact the user lacks autonomy in searching for information. While WebMD and the Mayo Clinic have very different sites, both organizations are private. The Centers for Disease Control and Prevention's (CDC) website leans towards information for the public, yet there is also information for physicians and researchers, like Mayo Clinic's website. However, the sections for consumers versus information that is available for health care providers and researchers is not given similar weight like it is presented on the Mayo Clinic's website. Overall the CDC's website is well laid out and easy to navigate from the homepage (Figure 3). The focus of the CDC is, as the name of the organization implies, prevention. The CDC's homepage is crammed with information that can be confusing and over whelming, much like WebMD's homepage. Yet, the CDC's homepage is overflowing with a hodgepodge of information while WebMD is a cacophony of apps, links, and advertisements. The other thing that the CDC's homepage has in common with WebMD's homepage is the presence of tools for the users. However, the tools on the CDC's site, while it requires choice, it does not necessitate the inputting of user data. For example, users can opt to listen to podcasts, download widgets for their personal websites and blogs, or subscribe to an RSS feed on different topics such as travel notices, flu prevention, or outbreaks happening domestically and abroad. Comparing WebMD, Mayo Clinic, and the CDC's websites provides more information on the different ways that consumers are being trained to use an amateur version of the medical gaze.



Figure 3: CDC Homepage March 22, 2011

Diabetes Subsections

WebMD

WebMD arranges disease subsections in a similar way to the homepage. The left hand navigation column is broken down into “Diabetes Home”, “Diabetes Guide”, and “Related to Diabetes” sections. Factual style information about diabetes is linked to in the diabetes guide. This section is first broken down by type of diabetes: Type 1, Type 2, Gestational, Prediabetes, Diabetes Insipidus and ends with Support & Resources. This indicates that WebMD is interested in providing information regarding disease maintenance, not prevention. Furthermore, user will need to either already have a diagnosis of a particular type of diabetes or will need to have a

basic knowledge of the different types of diabetes to know where to begin their search. Since research has shown that African American populations are less likely to receive a diagnosis of diabetes, arranging the page in a way that assumes a person has already received a diagnosis is actually exclusionary. To be more inclusive and mindful of the racial health care disparities as it relates to diabetes, WebMD's content creators and editors should begin the diabetes subsection with common concerns such as symptoms, risk factors, or prevention.

Clicking on the Type 2 diabetes link in the left hand navigation bar will take the user to a page that contains links to basic information about Type 2 diabetes. However, it is located in the middle of the page and users must scroll down to locate those links. Clicking on the link for risk factors you find a BuzzFeed style listing of 12 risk factors. WebMD's list of risk factors is written in a way that is very pointed. Instead of removed neutral information, the statements are written as if a physician is speaking them to a patient. This brings forth a certain level of anxiety to a degree as well as a degree of, as suggested in Chapter 2, a level of anthropomorphism. As stated in Chapter 2, Deborah Lupton calls the process by which the boundaries between human and machine begin to blur to the point where the computer becomes an extension of the human, psychotopography. I would argue that in the case of the pointed language used by WebMD writers, they are leading and coaxing the user into breaking the barrier between human and machine. While not exactly psychotopography as Lupton describes it, I would argue it is taking psychotopography a step further, it is not merely an extension of a human, but it becomes human in an of itself.

Each risk factor offers little explanation ("You've had heart disease"). Furthermore, the only mention of race disparities is the last listed factor that states: "You are Hispanic, African-American, Native American, or Asian American. Diabetes is more common among these groups

of people.” This statement gives no information about why there is a racial health disparity, just that there is one. While it is good that there is mention of this, it is not addressing any reasons why this must be. In not addressing the reasons why there are racial health disparities, it comes off as if WebMD is offering a death sentence to those who inhabit the listed racial categories.

In the "Take Action" section, there are 4 pictures with corresponding links. Three pictures feature White people and the fourth picture is of breakfast tacos. Of the three pictures with people, one is male and the other two are female, yet the male is the only one whose face is shown at all. He is shown from the waist up, while the two images of the women are truncated to show only parts of the face and their hands.

There is also an online tool that allows users to check their blood sugar levels to determine if it is normal or not. This is an example of the expectation of the patient becoming knowledge in identifying illness, in a way that was previously reserved for health care professionals. Determining what is a normal blood sugar level, is something that used to be reserved for doctors. To know what is the range of normal a patient would need to first schedule an appointment with a doctor, have their blood drawn, sent to a laboratory, then the doctor will determine the results as normal or abnormal. Now the information and training necessary can be found with a few clicks of a mouse. The knowledge is no longer reserved for a select few behind the walls of a medical school. Cyberspace has created a location in which patients can acquire the knowledge to read their own bodies and the bodies of others as diseased. A succinct overview of Type 2 diabetes appears at the bottom of the page. A patient who is unfamiliar with Type 2 diabetes would need to wade through a page worth of information before they encounter an easy to digest summation of the knowledge related to diabetes.

As noted in chapter 3, research has shown that racial health and health care disparities that are related to diabetes incidences in the African American community are largely related to socioeconomics. This information is absent from WebMD's diabetes page, thus, a person who knew nothing about diabetes relationship to socioeconomic status, would most likely assume that diabetes is related to genetics and personal lifestyle choices only. The information that is provided on the diabetes subsection makes the assumption that the users of the site have reliable consistent access to a primary health care provider, have the leisure time to conduct research about their disease, and the socioeconomic means to buy appropriate food.

While navigating the diabetes subsection homepage, I was prompted to subscribe to a series of newsletters through a pop up window. This indicates a need to drive user traffic. Registering for newsletters to "keep up to date with the latest news and features" is a common function of many websites. The sidebar contains a link for references related to diabetes. The articles that are attached to this particular section vary in scope from an article about Nephrogenic Diabetes Insipidus to articles about how to cook a diabetic friendly dinner. This is another example of content creators and editors creating content that assumes users have a diagnosis, a certain level of knowledge about diabetes, and the socioeconomic means to treat and manage the disease.

The reference section is not very different from the "news" section for the most part; the difference lies in the sprinkling of more medically specific articles among the articles about diet and exercise. It gives a false sense of knowledge to the users. Calling the section the Reference might also be off putting to some people who are seeking information about diabetes.

The medication section links to WebMD's larger medication database, that contains information about the medication as well as have consumer reviews. The medication database

allows users to search the database by condition specifically. Searching for diabetes, returns a long list of further possibilities. Again if the patient-consumer does not already have a diagnosis it will be very difficult to understand that information that is present. Thus the helpfulness and further information and knowledge that a user can acquire is actually limited to those that have some type of prior knowledge or that have already had a previous diagnosis. Thus WebMD acts as a gatekeeper of knowledge. WebMD is only helping those that first have a specific level of knowledge about diabetes. A consumer must prove themselves worthy before proceeding through the site.

While navigating through the many layers of the diabetes subsection, I was struck by how many other diseases are also referenced or linked to – erectile dysfunction, cancer, heart disease – that I began to feel disoriented and found it hard to keep track of what information I deemed relevant, what information I had already consumed, and where I was headed next. Ironically, on the side of the page was a handy self-diagnosing tool for Adult ADHD. I would like to believe that this placement was unintentional, however, the result and implication was striking: create a layout, which is busy and constantly changing, then ask if a person has ADHD. In fact the volume of information and the busyness of each page was at times overwhelming. Considering I found the site to be overwhelming when I have a better than average knowledge of type 2 diabetes, I think it is safe to assume that people who are newly diagnosed or generally speaking have little knowledge of diabetes might struggle with finding the information they need. The difficulty in identifying information that is necessary is further exacerbated if a user is not comfortable with using the Internet in general or if they do not have consistent open and unlimited access to the Internet.

Mayo Clinic

Navigation to information about diabetes on the Mayo Clinic's website has certain similarities with WebMD. Specifically, the amount of knowledge it is assumed a user possesses. From the homepage a user must first navigate to the Patient Care & Health Info menu, then select the Diseases and Conditions section. At this point users must then select from a type of diabetes (e.g. type 1, gestational, etc) or by a condition related to diabetes (e.g. diabetic coma, hypoglycemia, ketoacidosis, etc). Thus, like WebMD, the Mayo Clinic's website is under the assumption that a person has already been diagnosed and at least informed of their condition and symptoms by a doctor.

I chose to navigate to the Type 2 diabetes page to compare to the experience of using WebMD. In doing so, I was struck by the ease of information layout. The Mayo Clinic has one advertisement on its Type 2 diabetes page which is for insulin. Unlike WebMD, whose page contains advertisements and prompts for other diseases and conditions, Mayo Clinic's page focuses on diabetes, only and no other diseases. The other thing that the Mayo Clinic advertises is itself. Mayo Clinic's diabetes page includes links to books and DVD by the Clinic about diabetes. In addition to Mayo Clinic products, there are also links to services that are provided such as the Mayo Clinic Healthy Living Program and Health Weight Plan. There are links to two types of e-newsletters, a general health newsletter and a diabetes specific newsletter. Both advertisements for the Clinic's newsletters are less intrusive than that of WebMD, which is a popup that obscures the user's access to information about diabetes. In fact, it would be fair to say that Mayo Clinic gives users agency in that they can opt to join the newsletter or not after thinking about it and do so when they see fit. WebMD on the other hand forces user to consider joining the newsletter immediately and consumers are not allowed to continue on to the

information that they are actually seeking without first interacting and determining immediately if they want to signup for the newsletter or not¹⁵. The agency or lack thereof that users have with using Mayo Clinic's and WebMD's websites specifically mimics two types of patient-physician interaction. WebMD is a one-sided version of information and they behave as gatekeepers. Mayo Clinic on the other hand offers a two way street in which information is given and the patient has the option to learn more at their pace. The patient is asking for more because they want more not because they assume it is what is expected.

The difference in interaction expectations continues into other areas as well. Specifically looking at the reference section of each site. The references for Mayo Clinic are more thorough than those of WebMD, giving complete author, date, and publication information with each source used. WebMD on the other hand lists the American Diabetes Association as its primary source with little more than titles such as "All About Diabetes" suggesting that their information is copied from the American Diabetes Association's website. One has to wonder what is the point of going to WebMD at all if all the information is actually from the American Diabetes Association's website.?

One way in which the Mayo Clinic's website parallels WebMD unfortunately is by minimizing the racial disparities of morbidity for diabetes. Unlike WebMD, the Mayo Clinic writers do give racial health disparities associated with diabetes more prominence, listing it as the fifth risk factor instead of the twelfth (i.e. last). Yet it also negates that difference by stating: "Although it's unclear why, people of certain races – including blacks, Hispanics, American

¹⁵ It is possible to signup for WebMD's newsletter without using the popup. At the very bottom of the page, the last sidebar box is also a newsletter signup. However, it should be noted that WebMD's signup by choice is almost hidden away. Mayo Clinic has signups for both of its newsletter clearly displayed beside the first 2 paragraphs of information.

Indians and Asian- Americans – are more likely to develop type 2 diabetes than whites are.” The previous statement is naïve at best and an outright lie at worst. There has been extensive research done about the racial health disparities that are seen with diabetes and it has been well documented that prevention, prevalence, diagnosis, and treatment quality are related to socioeconomic status which is correlated with race (Robbins et al., 2000; Black, 2002; Kennedy et al., 2007).

Centers for Disease Control and Prevention

The link to information about diabetes is clear on the CDC’s homepage. Clicking on the diseases and conditions dropdown, a user will see diabetes listed as the third disease (under ADHD and cancer). I would argue that the CDC’s diabetes subsection is much more user friendly than either WebMD or Mayo Clinic’s. The page is clearly laid out and lacks distractions in the form of advertisements and pop-ups. Further more the representation on the CDC’s website is more diverse than WebMD. There are few images on the CDC’s diabetes subsection, but the images that are present include people of color and men and women. The site does lack diversity in terms of age by lacking the inclusion of elderly people.

Another clear distinction between the CDC website and the previous two sites, is the focus on prevention rather than treatment post-diagnosis. Links on the subsection homepage include “Who’s at risk?”, “National Diabetes Prevention Program,” and “the Basics of Diabetes.” Thus users can gather information about diabetes before they have been diagnosed. Clicking through to “The Basics of Diabetes,” the information links on the left hand navigation page again are clear, straight forward and are geared to all levels of understanding. Under the section “Basics,” a user can choose links to either “What is Diabetes,” “What is Prediabetes,” or “How can I prevent Diabetes.” Thus, the focus on prevention is reiterated. In fact the next

section is dedicated to “Who is at Risk?” It is not until the third section of the left hand navigation panel that a user gets to information for those that are post-diagnosis.

Within the section for those with diabetes (“Living with Diabetes”) the focus is not direct medical care per se, but rather everyday living life considerations such as how much exercise should a person with diabetes get and how to pay for diabetes related expenses. WebMD and Mayo Clinic both focus on care and treatment in the form of medications and doctors visits. This difference in focus might be expected since when considering the focus of those websites versus the CDC. The CDC is concerned with prevention, WebMD and Mayo Clinic are concerned with treatment, which makes sense. However, in doing so the CDC addresses issues that are more integral to diabetes diagnosis. As noted in Chapter 3, African Americans have a higher incident rate for Type 2 diabetes and have worse health outcomes related to diabetes. In focusing on prevention it appears that the CDC addresses some of the facets associated with higher incident rates and higher rates of complication and mortality. The simplistic layout of the CDC’s website also brings focus back to the information rather than distractors such as product advertisements. Part of the simplicity is the lack of imagery. However, within the subsection about the “Basics of Diabetes,” there are only two images present. Both of the two images feature white women who appear to be in their 30s. Initially it seems as if the CDC’s effort of diversity that is present on the original page of the diabetes subsection is lost. But upon further investigation, it is revealed that there is a focus on racial identities and risk for diabetes.

The left hand navigation bar includes in the “Who is at Risk?” section the initial breakdown comes in the form of racial categories, with African American being the first listed. Clicking on that link reveals approximately a paragraph worth of information. The majority of the information listed links to the higher incidence of diabetes as genetic variation, which is why

there is a difference in morbidity. However, the last line of this section states: “In addition, poverty, lack of access to health care, cultural attitudes and behaviors are barriers to preventive and diabetes management care for some minority Americans.” While small, it is an acknowledgement that morbidity of diabetes has ties to socioeconomic factors such as poverty and lack of adequate health care and is not merely genetic and behavioral.

HIV/AIDS Subsections

WebMD

When moving on to investigate the HIV/AIDS subsection, an interesting difference first emerges. While there was a noticeable lack of Black bodies on the main homepage and on the diabetes subsection pages, there is a strong presence of people of color on the HIV/AIDS subsection homepage. On the main HIV/AIDS subsection homepage the three rotating images that are used are completely devoid of white bodies, utilizing Black and Asian models only. Even the advertisements on this particular page feature a Black woman. In fact, the absence of White bodies is almost shocking. The only presence of White bodies is for other diseases: osteoarthritis, adult ADD, and MS. There is one place in which there is a white face associated with HIV/AIDS and that is an image of Princess Diana that links to an article titled “History of HIV/AIDS.”

Following the link to the slideshow of the History of HIV/AIDS (according to WebMD) the trend of hyperrepresentation of Black people while there is a simultaneous absence of White people continues. While there are a number of images of unnamed Black people used in the visual timeline, the majority of images of White people that are used are pictures of famous White people with HIV (e.g. Rock Hudson and Ryan White). There are two images that contain

unnamed White people. The first image that is not of a famous White person is the image used of a patient with Kaposi's sarcoma lesions. The accompanying text describes the historical moment when the connection to HIV/AIDS was made between otherwise healthy gay men who are becoming gravely ill with PCP pneumonia and Kaposi's sarcoma. Thus there there is a presence of White bodies in this instance there is also the connection made to another oppressed group: gay men. The second image of an unknown White person is of a man organizing multiple medications in what appears to be his living room. This image is also interesting in that it is classed as working or lower class. The man in the image is wearing a wrinkled white tank top; he has meticulous sideburns and a pompadour. The timeframe he is supposed to represent is 1998-2000, thus this cannot be considered to be styles that were common at the time. In the background you can see through to an old sliding door into a kitchen with "apartment" cabinets: cheaply laminated cream cabinets with brown wood trim. The furniture that is visible in the living room is modest and sparse. Since the rest of WebMD is classed as middle and upper class, the presence of a working or lower class individual invokes another oppressed category of people. In both instances where images of White people are used the people are part of another oppressed category: gay men and working class respectively. WebMD's treatment of HIV/AIDS is as a disease that white middle class heterosexual people are immune from. While at the same time, they are the only ones that actually have any other form of illness and/or are the only ones worth treatment. As noted by Lupton (2012), metaphors used to describe HIV/AIDS often invoke judgment and morality such that HIV/AIDS is a punishment "living unhealthy lives, for taking health risks, for excesses of diet and lifestyle, weakness of will, self-indulgence and addiction" (p. 59). This is clearly seen on WebMD's HIV/AIDS subsection and timeline. The

people represented as having HIV/AIDS are those that often invite moral judgment because of their membership into oppressed categories be it racialized, queered, or classed.

Mayo Clinic

Much like the subsection for diabetes, the Mayo Clinic's subsection for HIV/AIDS is straightforward and lacks visuals. After clicking on the link for HIV/AIDS disease link, users are taken directly to a page with definitions that differentiates between HIV and AIDS. This distinction between HIV, the virus that causes AIDS, and AIDS, the collection of illness caused by immunodeficiency, is not easily found on WebMD. As well as making the distinction between HIV/AIDS, the landing subpage gives information about how the virus is transmitted, the transition between HIV to AIDS, and most importantly tells about the difference AIDS death rates in developed nations versus what is seen in countries in Africa and Asia. The fact that the Mayo Clinic immediately, states that there is a difference in mortality rates based on nations' economic levels is significant because without explicitly stating so, the Mayo Clinic still acknowledges that there is economic inequality when it comes to people's outcome for their experience with the disease.

Also on the homepage of the HIV/AIDS subsection is a clear navigation pane with links to symptoms, causes, risk fact, test and treatments, as well as prevention and coping with HIV. An important thing that the Mayo Clinic website does that WebMD does not is to acknowledge racial mortality differences on a global scale however the Mayo Clinic ignores the racial differences in morbidity and mortality in the United States. The combination of WebMD's hyperfocus of representation of black bodies¹⁶ and Mayo Clinic's lack of racial

¹⁶ Also the representation of other oppressed groups. The case of the HIV/AIDS subsection of WebMD this also includes Asian bodies, gay white males, and working class white males.

acknowledgement at all is an interesting juxtaposition. Neither provides completely accurate information about HIV/AIDS morbidity and/or mortality as it relates to race, either explicitly or implied.

Centers for Disease Control

The CDC has two methods for accessing information about HIV/AIDS on the CDC website. To access the HIV/AIDS subsection users can go to the Sexually Transmitted Diseases link. From there users then can click a link to access HIV/AIDS information. However the link is not necessarily easily seen at first, it is almost hidden within a series of links to other sexually transmitted diseases such as herpes, gonorrhea, and pelvic inflammatory disease. However, it is important to note that pictorial representation while few are diverse. Three images located at the top left hand side of the STD page contain an image of a black couple, white couple, and an interracial gay couple. Following the HIV/AIDS link takes user to information about HIV/AIDS as it related to other STDs. Outside of three quick statements regarding the relationship between HIV/AIDS and other STDs, there are links to fact sheets, other STD pages, and at the bottom of the page is a link to the HIV/AIDS main subsection. If a user went through this method of accessing the HIV/AIDS subsection, it would prove rather difficult to locate the bulk of information.

It is also possible to access the HIV/AIDS subsection by going to the CDC topics index directly. However, this is not especially easy to find either. Among the three websites, WebMD, Mayo Clinic, and CDC, the CDC has the most comprehensive amount of information as it relates to HIV/AIDS among Blacks. Under the “Who’s at Risk for HIV?” link in the left hand navigation panel, users have the option of continuing to risk behavior, racial/ethnic groups, gender, age, and other. It is noteworthy that while WebMD and the Mayo Clinic both have very

little in regards to HIV/AIDS and race, the CDC contains a wealth of information. In the racial and ethnic groups section of the “Who’s at Risk?” area, there is a break down for African Americans, American Indians/Alaska Natives, Asians, and Hispanics/Latinos.¹⁷ The landing page of this section opens with emphasizing that HIV transmission in the United States is through anal and vaginal sex and intravenous drug use. It goes on to articulate that some racial groups have higher rates of HIV infections which means there are more people that a person may encounter through sex or IV drug use. Most importantly, however, that it does acknowledge that socioeconomic factors, such as income, effect a person’s risk for HIV infection. Following the link for African Americans leads to fact sheets, podcasts, and articles about prevention, campaigns, and funding for prevention projects. Unlike WebMD and the Mayo Clinic, the CDC explicitly states, “Blacks/African Americans have the most severe burden of HIV of all racial/ethnic groups in the United States.”

Selling Medical Fear

When taken in isolation it may seem that WebMD might be in the business of selling health care. But when taken in conjunction with other health websites, such as the Mayo Clinic and the CDC, that becomes less clear. In addition, when we consider the Health 2.0 movement, WebMD becomes less about passing knowledge onto the user in a passive one-way model. Instead users become producers of data and labor creators. Responsibility of information procurement and (re)creation is thus placed on the user. However, the user is making choices

¹⁷ By excluding White as a racial category the CDC website illustrates the common problem of White invisibility which the main feature of White supremacist ideology. It can be argued that it would also be problematic to have a racial category of White and state that statistics and figures for Whites are used as a baseline for comparison to other racial groups, however, that is how the data is analyzed so it would be an accurate representation.

and decisions about content creation in a guided fashion. The user can only create an experience in the confines of what is being offered to them by the website. It is not expected that the user will be determining the validity of the information that is presented. As such WebMD is able to create a reality within its website that mimics offline reality, specifically racial health care disparities.

WebMD presents an image of health that is limited to people who are White. Potentially, no place is this seen more clearly than in the Symptom Checker feature. Users can access the Symptom Checker from the homepage where the default body is a drawing of a white male (Figure 4), what is similarly seen in medical drawings used to teach anatomy.



Figure 4: WebMD Symptom Checker Start

Once the user clicks the Get Started button, the body then switches to a drawing of a White woman's body (Figure 5). It is at this point where there is further indication of the precursors of the Health 2.0 movement. Users are asked to input their data so they will be able to self-diagnosis; they can even generate a doctor's report. Thus the need for a physician is reduced and in some instances can be completely eliminated.

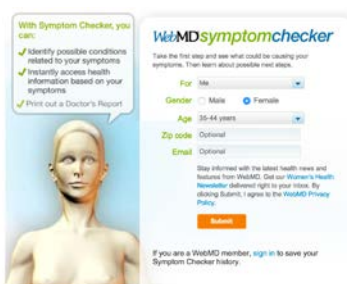


Figure 5: WebMD Symptom Checker user input screen

Once the user has entered their information, they are taken to a screen where they then select the area of the body where they are experiencing symptoms. When hovering over an area of the body, the body parts change color to indicate that they have been selected. Instead of the body parts being highlighted, made lighter, or emphasized by a dramatic color such as red, the body part becomes darker. The neutral beige body's damaged, disease, broken parts become brown (Figure 6).¹⁸

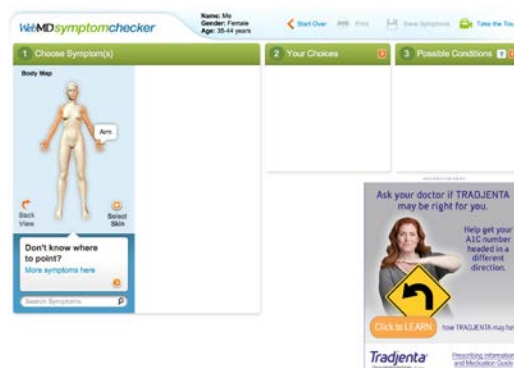


Figure 6: WebMD Symptom Checker body part selection screen.

It is important to note that the creators of the code that makes the diseased parts of the symptom checker brown, were not likely creating this element with racial malice in mind. However, this lack of awareness or insight into the racial connotations of the use of a healthy body as white and

¹⁸ The advertisement that is part of this page is for diabetes management medication. It should be noted that the image that ended up being used is not for a person who falls into the categories that have the highest incidence of diabetes. This advertisement, thus can be seen as another example of silencing racial health disparities.

the diseased body as brown, provides an acute example of the underlying biases that lead to similar racial health care disparities online that are seen offline.

The symptom checker also gives users the chance to become amateur producers of medical knowledge and practitioners of the medical gaze. If we return to Foucault's notion of the medical gaze as the process that makes doctors experts, than we can draw parallels with the symptom checker. Users are given a list of possible symptoms, some of which are similar enough that it is difficult to understand how a user would tell the difference between "joint aches," "joint pain," or "morning joint stiffness." The symptom checker, specifically, WebMD and health websites in general, assume that a user knows what the difference is between an "ache" and a "pain." What health care professionals learn through the medical gaze is assumed to be understood by the patient. To proceed, I chose "joint aches" which led to only one possible condition: mucopolysaccharidosis I (MPS1), a rare genetic disease (Figure 7).

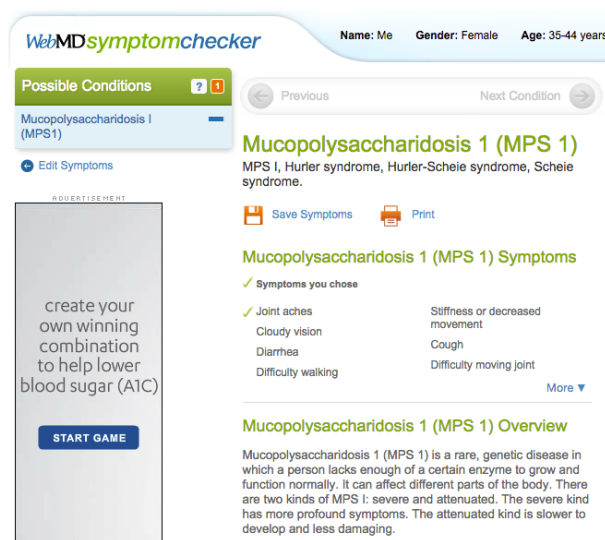


Figure 7: WebMD symptom checker possible conditions.

Joint aches were one of seven symptoms of MPS1 listed. The symptom checker is a perfect example of how WebMD has been able to sell medical fear. What might be the result of too much typing or an overzealous workout is now being sold as a rare genetic disorder. As such,

users are expected to continue to use WebMD to research their possible disorder, including inputting more data, driving the user to learn the (cyber)medical gaze. As this occurs, there is a skewed feeling of the user becoming empowered by actively addressing their health. In reality, this progress feeds into data mining by for-profit health companies.

Healthy Black Bodies

BlackDoctor.org at first glance is similar to WebMD.com in some basic structural ways. BlackDoctor also utilizes popup windows to have users subscribe to emails lists and their newsletters. The homepage of the site is also flanked by links to BlackDoctor's YouTube channel and Facebook pages. The top center of the page contains a rotating image, like WebMD's homepage, that includes information about light topics such as "No Cook Brunch Recipes," and "7 Tips to Look & Feel Great in Your 60s." The images in the rotating banner also include more serious topics such as the proper way to use sunscreen and the signs of dry drowning. However, unlike the other health websites examined, the images used in the rotating homepage banner are all people of color; hyper-representation of Black bodies replaces the absent of blackness that is seen on WebMD. Below the banner of rotating images, is a series of photos, laid out in two columns, that link to health and wellness articles. In an interesting departure from WebMD and the other websites studied, BlackDoctor also includes several pieces featuring celebrities, such as Morgan Freeman, Kendrick Lamar, and Jackie Joyner-Kersey. These short articles incorporate brief interviews with the celebrities to highlight different diseases and other health topics such as Fibromyalgia, depression, and chronic pain management respectively (Figure 8). The articles that include celebrity interviews mostly contain information about the disorders with quotes from the celebrities talking about their lived experience with the disorder weaved throughout the piece.

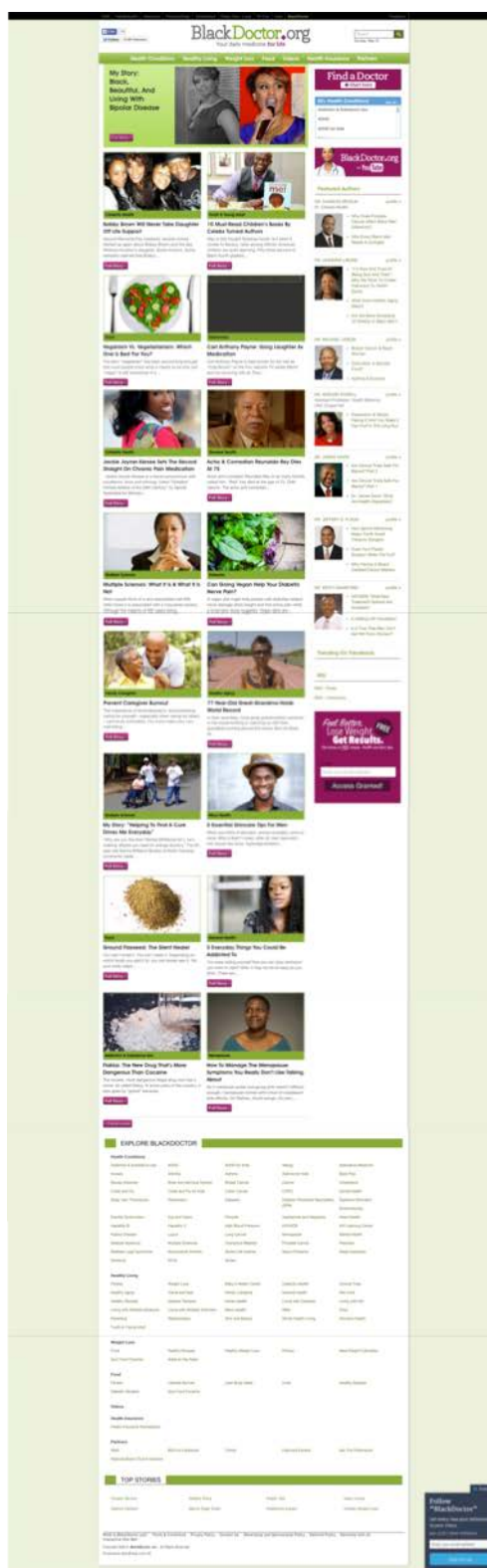


Figure 8: BlackDoctor Homepage May 31, 2015

It is an interesting method of conveying information that is not seen on WebMD, Mayo Clinic, or CDC websites. In one sense, the articles humanize the celebrities but more importantly it also brings a reality to the diseases discussed instead of it being a series of facts and figures layout on a page with stock photos of models. Humanizing the illnesses and diseases that are written about also brings BlackDoctor into the Health 2.0 movement in a way that is absent from the other health website examined in this project. As argued by Levina (2012a), the Health 2.0 movement seeks to open a space for users to be empowered by creating the notion of a user-centered experience.

I would argue that writing articles in such a way that shifts focus from the disease to the human subject, like the previously mentioned BlackDoctor articles, encourages the concept of a user-centered experience because the human becomes the subject of study not the disease. While the focusing on the human aspect of a disease could be considered an improvement, it does not negate from the reality of BlackDoctor's existence as part of a larger for-profit company.

BlackDoctor is a part of Interactive One (iOne), a company that specializes in the production of Internet content specifically for Black audiences (Huslin, 2008). iOne is a spin off of Radio One and was created especially to target Black audiences. The holdings for iOne include various websites that are geared towards Black web audiences such as Black Planet, Hello Beautiful, The Urban Daily, News One and theGrio. Like WebMD, BlackDoctor as a for-profit company generates revenue from advertisements. Also like WebMD, there are advertisements for pharmaceuticals companies' medications on the top banner and sides of the BlackDoctor homepage. Unlike WebMD, BlackDoctor takes advertising a step further and includes a video box on the right hand side that includes health product advertisements, such as Digestive Advantage, non-health advertisements for products like air fresheners, and video features on

non-health related topics, such as fashion. The mix of medically related and non-medically related advertisements suggests that BlackDoctor is attempting to be more of a wellness website rather than a health website¹⁹. The focus on overall wellness breaks from the traditional one way model of health care and embraces the proposed tenants of the Health 2.0 movement by adopting a holistic approach to health that focuses on aspects of a person's life outside of medical wellbeing as an indicator of overall health.

Diabetes on BlackDoctor

To access the section on diabetes on BlackDoctor, users must first navigate to the “Health Conditions” section linked in the main top navigation bar, which takes the users to a list of several common conditions. BlackDoctor's website has only two links to diabetes: Diabetes and Diabetic Peripheral Neuropathy. Therefore, users do not need to have a certain level of knowledge about the disease or have had a previous diagnosis to be able to effectively navigate to information. The diabetes subsection is clearly laid out with links to items such as symptom and treatment information. Unlike the other websites that were studied in this project, prominently listed among a list of articles about diabetes is one titled “Lack of Money & Access to Food Makes Cost of Being Black & Diabetic High.” This explicit acknowledgement of the socioeconomic factors that effect people's health experience is overwhelmingly absent from the other sites that were part of this research. This absence is striking since socioeconomic factors have some of the strongest effects on people with diabetes health outcome. Furthermore, the information in the diabetes section provides a basic one sentence definition of diabetes,

¹⁹ The National Wellness Institute conceives of wellness as acting on six dimensions: occupational, physical, emotional, social, spiritual, and intellectual (“The Six Dimensions of Wellness”). As such wellness extends beyond the mere absence of disease to include all aspect of a persons life.

“Diabetes is a disease in which the body has problems producing or using insulin, a hormone needed to convert sugar, starches and other food into energy,” then continues to define the disease as it relates to African Americans specifically. This explicit focus on the prevalence of diabetes for African Americans is almost shocking when compared to the information provided by WebMD, the Mayo Clinic, and the CDC which mostly ignores or glosses over the socioeconomic factors associated with diabetes prevalence.

Although the definition section of the diabetes subsection on BlackDoctor is extremely different from the other websites studied, the remainder of the subsection is very similar to the other sites examined. The diabetes subpage, like the homepage, has advertisements for medication and non-health related products. The medication that is advertised in this instance is a diabetes drug, Trulicity, which regulates a person’s insulin. There are links on the side bars for BlackDoctor features such as the website’s YouTube channel and a box where users can sign up for BlackDoctor’s emailed newsletter. However, there are also advertisements for a furniture company, and for a book titled *Dear Father* about absentee fathers. The latter advertisements seem odd and out of place at first. Yet, if we return to the idea mentioned previously that BlackDoctor is actually a wellness site rather than merely a health site, the use of advertisements for products related to other parts of living and well being outside of physical health is understandable.

HIV/AIDS on BlackDoctor

The HIV/AIDS subsection of BlackDoctor is similar to the diabetes subsection. Users must first navigate to the Health Conditions section from the homepage, and then navigate to the section on HIV/AIDS. In the definition section of the HIV/AIDS subsection, also in the same manner of defining diabetes, users are first provided with a definition but then it proceeds into

defining and characterizing the disease based on prevalence in the African American community. The CDC's section on HIV/AIDS was the only one of the other websites that was examined that focused on the prevalence and incidence of HIV/AIDS specifically in the Black community. In addition, several of the feature articles in the HIV/AIDS section on BlackDoctor, focus on activism and awareness campaigns. The prevention approach that is taken by BlackDoctor is similar to that seen on the CDC's website. While it stands to reason that the CDC would take a preventative approach from an epidemiological perspective, BlackDoctor could have approached the task of providing information about HIV/AIDS from the perspective of care and treatment after infection. While BlackDoctor does not ignore the care and treatment aspects of HIV/AIDS, the website focuses primarily on prevention and activism. In this regard it is more similar to the CDC's website than that of WebMD's focus on the illness. Furthermore, BlackDoctor shows Black bodies in relation to HIV/AIDS as living with the disease and preventing the spread of the disease rather than as dying and transmitting the disease like was represented on WebMD.

“My concern is that in the glare of the media spotlight on the digitally disadvantaged, we become blinded to the other fact of significant black technomastery and new media activism despite tremendous odds.” -Anna Everett, Digital Diaspora: A Race for Cyberspace

CHAPTER 5: CONCLUSION

The examination of WebMD.com reveals underlying ideologies that reinforce racial health care disparities. However, the ways these disparities are exhibited in cyberspace – at least on the surface – seem different than the way the disparities are seen offline. Racial health care disparities offline are thought of in the context of one-way interactions, usually individual interactions, between the health care provider and the patient. Racial health care disparities are also related to a lack of access to (quality) health care facilities. In other words, health care providers fail to give equal treatment to patients based on unconscious racial biases or quality health care facilities and providers are not located in areas that serve disadvantaged people.

In reality, online racial health care disparities are not much different than offline racial health care disparities, as can be seen when examining WebMD.com. Health websites, such as WebMD.com appear to be mechanism by which users can gain health knowledge. It is a means that patients can be empowered and move from a one-way conversation with health care providers into a two-way negotiation. At minimum patients are able to use health care websites as a second opinion, rendering the physician as no longer the sole keeper of health knowledge. Yet as argued by Levina (2012), health care in cyberspace is an illusion that is sold as reality in the Health 2.0 movement. Patients’ use of health websites as a site for information gathering is the precursor for the Health 2.0 movement. Health websites, such as WebMD are also mechanisms of maintaining systems of paternalistic control, however, it is a more hidden than what is seen in offline environments. Furthermore, the information that is presented on health care websites is limited to what content creators and editors chooses to provide. Users of

Internet health websites, like WebMD, are limited to what they are given by the corporation, who is attempting to maximize profit rather than maximizing the quality and quantity of health information and knowledge that is given to their users. The training that users receive in the medical gaze is based only on what is given and they are not given a chance for an alternative.

WebMD Corp owns so many consumer health websites that it is difficult to access a for-profit site that does not perpetuate some of the unintentional stereotypes and prejudices that support systemic racial health care disparities. Therefore, patients do not have many online options to access alternative information that could potentially combat the oppressive nature of the medical gaze. In offline health training, however, when given the chance or even just the option of receiving training in how to interact with patients in a more equitable manner most physicians choose to do so (Stevenson et al., 2004). Users of health care website do not have this choice. Yet, the responsibility of health care is shifting from the health care provider to the patient through the proliferation of health websites and the continued growth of the Health 2.0 movement.

Health Responsibility

Winner (1986) argues that “it is usually taken for granted that the only reliable sources for improving the human condition stem from new machines, techniques, and chemicals. Even the recurring environmental and social ills that have accompanied technological advancement have rarely dented this faith” (p. 5) If we accept this to be true, then it stands to reason that, in the case of online health sites, there is an unflinching belief that they will improve the ability of patients to acquire health information. This belief/hope is used as a means to help propel the Health 2.0 movement forward, urging the empowerment of patients through web use. As Levina (2012b) notes “expertise is redefined not through institutional medical training but rather as

access and participation in web-based communities or networks where information is shared among many interested parties and individuals.” (p. 19). Health 2.0 pushes for the patients to be more involved with their own health care. In fact, it encourages patient driven health care, rather than a top down model in which the physician is the keeper of medical knowledge that they will bestow upon the patient, in that the focus is in a method of health care that is based on people’s ability to navigate through social networks and communities (Levina, 2012b).

In laying responsibility on the consumer there is a need to understand the implications of that shift. Namely that all the trappings of previous health knowledge coming from the medical profession is passed to the consumer, including stereotypes, assumptions, and silences that help to perpetuate racial health and health care disparities. For example, in a study by van Ryn and Burke (2000) physicians rated Black patients as significantly less educated than White patients even when controlling for actual educational attainment. It can be difficult to identify physicians’ prejudices outside of specific studies on the subject, thus making it easier to ignore the realities of sociohistorical effects on health and health care. We can once again look to the Health 2.0 movement to see how inequality affects people’s ability to participate fully in the space of purported radical health care. Returning to the work of Marina Levina (2012b), her argument is that Health 2.0 is far from radical. In fact, we see that Health 2.0 undermines progress that has been made in information about racial health disparities. Health 2.0, like health websites such as WebMD.com before it, must assume that users have easy access to the internet. Furthermore, it allows users to ignore inconvenient truths about inequality in our society by making difference invisible. WebMD.com shows healthy individuals as very similar. Specifically the people that represent dominant social identity categories: white middle-class and

often male. Thus racial health care disparities are continued in spaces like WebMD.com by excluding racialized bodies except when showing disease.

This distinction reinforces the idea that health is the responsibility of the patient. Laying responsibility with the patient when discussing health and medicine at first is an issue of compliance. The doctors are the ones who possess the medical knowledge (and the medical gaze) and it is their responsibility to translate that information to the patient. However, it is the patient's responsibility to carry out the directives of the doctors. Health 2.0 seemingly shifts how patient responsibility is exhibited. Patients are now responsible for training themselves in an amateur version of the medical gaze. While the medical community is at the very least aware of racial health care disparities and has made attempts to end disparities, there is nothing to indicate that corporations are concerned with acknowledging, let alone ending racial health care disparities online. As a result the emergence and proliferation of Health 2.0 helps to erase the realities of health and health care disparities. Specifically, when health becomes focused on an individual's responses and behavior it becomes easier to ignore the systemic nature of health disparities- one can use a framework for examining health disparities in terms of what someone did not do rather than in terms of what society has not done for a group of people.

Finding Healthy Black Bodies in Cyberspace

Outside of mainstream (i.e. white) spaces there have been spaces created specifically by/for Black people. In cyberspace this remains true. Websites such as BlackPlanet, indicate the need of such spaces that address the absences that are present on mainstream websites. Which raises the question: Is it necessary to create a race-specific health website? The website BlackDoctor suggests that it is. I would argue that BlackDoctor is the Black version of WebMD, a health care and wellness website carved out of the vastness of cyberspace specifically for Black

bodies. BlackDoctor is problematic in similar ways to WebMD in that it is geared to women and the middle/upper class, but unlike WebMD there is no absence of Black bodies. Also a list of featured authors is prominently displayed on the homepage, all of whom are doctors. In other words, BlackDoctor is filling a void in two important ways: they are making Black bodies present and visible as subjects but they are also making Black bodies visible as the health experts, as the doctors.

Everett (2009) makes the association between the rhetoric of the “digital divide” and racial power and privilege relationships that exist offline. And rightly notes that “in the glare of the media spotlight on the digitally disadvantaged, we become blinded to the other fact of significant black technomastery and new media activism despite tremendous odds.” (Everett, 2009, p. 149) The reach and scope of iOne websites should not be underestimated because it is a niche web market. The influence of iOne holdings can be seen in the fact that Obama administration officials hosted an “Open for Questions” event on September 12, 2011 (Schullman, 2011) where they would answer questions from the public. The event occurred following President Obama unveiling the American Jobs Act, a major piece of legislation, the previous week. People could submit questions to the event through iOne websites including theGrio, Hello Beautiful, and News One. This relationship between a White House level event and iOne websites points to not only the traffic and visitation of Black users, showing that Black users are very much present in cyberspace, but also that Black technology audiences are important to the social framework of our society. While the preceding examination of WebMD highlights the exclusion of people of color, it might prove to be more beneficial to see it as an opportunity to consider what technoactivism for health care would look like in cyberspace.

Racial Health Care Disparities in Health 3.0?

In writing the conclusion of my research, many days have been spent in various coffee shops. One such space removed their register in favor of an iPad. Perched anarchistically beside the new "register" was a hand written sign saying that they could only accept small bills, presumably because they now lacked a drawer with bills and change. Coffee shops to a degree have become mobile offices in which one can spy the latest tech hardware in use. However, excluded from those in this new system of monetary exchange are those without a card (debit or credit) or the forethought to bring "small bills." It is convenient but it has a certain level of exclusion as well. This makes me wonder if we will eventually move to similar systems in doctor's offices. A trip to a doctor's office a few years ago revealed a sign stating that they only accepted cash or checks no credit cards. The lack of the desire for this office to accept cards made me question the doctor's ability. It reduced my level of trust because he did not embrace technology. When in fact his decision to not accept cards potentially was in an effort to reduce costs to the patients, it invoked a feeling of distrust for not using modern technologies.

It has become clear that health care and technology has been intertwined to the point that one cannot be present without the other. Furthermore, technology has allowed patients to engage in their health care to the point that it is expected that the patients will be pro-active participants in their health care. It is no longer assumed that health care providers are the only ones with medical knowledge and that care is a one-way information receiving system. Instead, now the responsibility of the patients to engage in a dialogue with their health care providers is mitigated with technologies such as websites like WebMD. Furthermore, Web 2.0 technologies have lead to the emergence of the Health 2.0 movement, which places health and health care responsibility more squarely with the patient than with the health care professionals. However, as online

technologies develop the racial health care disparities that exist offline are being continued online as well. Web 3.0 has largely been touted as the next big thing and with it the emergence of Health 3.0 for the general public is not far behind. Web 3.0, also known as the Semantic Web, is technology that allows for data to be cross-referenced and contextualized providing targeted information to the person searching (Feigenbaum et al., 2007). In theory, this will provide better search results for users, however, I question whether or not institutional racism in general and racial health care disparities specifically will continue to move through cyberspace with each new iteration of Internet technologies. Thus, potential the next question is not about whether or not racial health care disparities exist in online spaces like they do in offline environments. Rather, the questions should lead us to interrogate the reality that both offline and online environments are in need of proactive attacks against institutional racism in both offline and online health care environments.

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